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	08/22/2024

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. 42079 Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that the resident and/or the resident's responsible party was given the opportunity to participate timely in the development and implementation of a person-centered care plan for two of 45 residents reviewed (Residents 12, 77). Findings include: The facility's policy regarding care planning, dated July 1, 2024, revealed that the resident and their representative will be given the opportunity to discuss their goals for care including their preference for advanced care planning. The results of the advanced care planning will be communicated to the resident's care providers and documented in the clinical record. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 12, dated June 19, 2024, revealed that the resident was cognitively impaired, was clearly understood and could usually understand others, and required assistance with care needs. There was no documented evidence that a care plan conference was scheduled or completed following the completion of the MDS or that notifications or invitations were provided to the resident and/or the representative. Interview with the Registered Social Worker on August 22, 2024, at 12:05 p.m. confirmed that there was a meeting scheduled on March 27, 2024, but the meeting was rescheduled for April 3, 2024; however, the meeting did not happen. The next meeting was to be scheduled in June, but the care conferences letters were not sent or scheduled. Interview with the Director of Nursing on August 22, 2024, at 12:22 p.m. confirmed that care conferences should be scheduled quarterly. A quarterly MDS assessment for Resident 77, dated July 19, 2024, revealed that the resident was cognitively intact, was clearly understood, able to clearly understand others, and required assistance with care needs. There was no documented evidence that a care plan conference was scheduled or completed following the completion of the MDS or that notifications or invitations were provided to the resident and/or the representative. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Registered Nurse Assessment Coordinator (RNAC- a registered nurse who is responsible for completing MDS assessments and who is often involved in the development of care plans) on August 22, 2024, at 7:12 p.m. confirmed that there was no documented evidence that a care plan conference was scheduled or completed following the completion of the MDS or that notifications or invitations were provided to the resident and/or the representative for Resident 77. The RNAC confirmed that the care plan meeting was missed. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 201.24(e)(4) Admission Policy.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 42079 Based on review of facility policies and clinical records, as well as observations and staff interviews, it was determined that facility failed to determine if residents were safe to self-administer medications for one of 45 residents reviewed (Resident 100). Findings include: The facility's medication brought in from home/self administration education policy, dated July 2024, indicated that residents were not permitted to bring in medications from outside the facility. If self administration was deemed safe then medications must be stored properly and should not be sitting out in open view on the night stand or over-bed table. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 100, dated July 31, 2024, indicated that the resident was cognitively intact, required supervision for care needs, had a diagnosis of cellulitis (infection of skin and tissue), and was taking an antibiotic. Physician's orders, dated July 24, 2024 included orders for the resident to receive two tablets of 800-160 milligrams of Bactrim DS (antibiotic) twice a day until July 27, 2024. The resident's record contained no documented evidence that an evaluation was completed to determine if the resident was capable of self-administering medications. Observations and interview with Resident 100 on August 19, 2024, at 12:06 p.m. revealed that the resident was sitting on his bed and there was a medication bottle on his over-bed table. The medication was labeled Bactrim DS from a hospital pharmacy. Resident 100 stated that the medication was from the hospital. The resident said he was no longer taking the antibiotic, but he had to take two of them when the machine was not working and staff could not pull the medication. Interview with Licensed Practical Nurse 8 on August 19, 2024, at 12:10 p.m. confirmed that there should not be any medications at bedside, confirmed the medication was Bactrim DS, and there were two tablets missing from the bottle. A nursing note, dated July 24, 2024, revealed that Resident 100 was admitted with cellulitis of his left lower leg and was taking Bactrim DS through August 27, 2024. A review of the medication administration record for July 2024 revealed that the 8:00 p.m. dose of Bactrim DS was not administered on July 25, 2024, because the medication was not available. Interview with the Director of Nursing on August 20, 2024, at 1:31 p.m. confirmed Resident 100 should not have had medication at bed side, had not been assessed for self-administration, and that the two unaccounted pills could have been taken when the medication was documented as unavailable. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 42079 Based on review of facility policies and clinical records, as well as observations and resident and staff interviews, it was determined that the facility failed to ensure that a resident's call bell was within reach for one of 45 residents reviewed (Resident 19). Findings include: The facility's policy regarding answering call bells, dated July 1, 2024, indicated that the facility provides residents with a means of communicating with staff. A call system was installed in each residents' room and toilet/bath area. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 19, dated July 29, 2024, revealed that the resident was understood, could understand, was cognitively impaired, and was totally dependent on two staff for assistance with bed mobility and transfers. A care plan for Resident 19, revised on July 30, 2023, revealed that she was at risk for falls related to being non-ambulatory. Interventions included having the call bell in reach at all times. Observations on August 19, 2024, at 1:00 a.m. revealed that Resident 19 was sitting a geri-chair and her call bell was not within in reach. The call bell was on the head of the bed behind her. Resident 19 stated that she needed changed. Interview with Nurse Aide 5 at 1:10 p.m. confirmed that the call bell was not in reach, and the nurse aide then unwound it from the enabler bar and handed it to the resident. Interview with the Nursing Home Administrator on August 22, 2024, at 3:10 p.m. confirmed that the call bell should have been in reach of the resident. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 41233 Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that the resident and/or resident representative had an opportunity to develop an advance directive (instructions regarding the provision of health care when the resident is incapacitated) or assist in formulating an advance directive for 12 of 45 residents reviewed (Residents 56, 57, 64, 66, 69, 71, 76, 77, 78, 80, 86, 89). Findings include: The facility policy regarding advance care planning meeting protocol, dated July 1, 2024, indicated that upon each resident's admission to the facility, the resident will meet with the appropriate member of the healthcare team to ensure their preferences (Living Wills, Medical [NAME] of Attorney, etc.) are recorded in their medical record. Information regarding Advance Directives is provided to the resident and their family by the facility during the meeting. The resident and/or representative will be given the opportunity to discuss their goals for care including their preference for advance care planning. In the event there are legal documents to be obtained, the resident, family and staff will coordinate as a team to obtain such documents and place them in the clinical record. Results of the advance care planning will be communicated to the resident's care providers and documented in the clinical record. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 56, dated July 10, 2024, revealed that the resident was cognitively intact, clearly understood, able to clearly understand others, and required supervision with care needs. A quarterly MDS assessment for Resident 57, dated July 30, 2024, revealed that the resident was moderately cognitively impaired, was understood, able to understand others, and required assistance with care needs. An admission MDS assessment for Resident 64, dated July 3, 2024, revealed that the resident was cognitively impaired, rarely understood, rarely able to understand others, and required assistance with care needs. A quarterly MDS assessment for Resident 66, dated August 1, 2024, revealed that the resident was cognitively intact, clearly understood, able to clearly understand others, and required assistance with care needs. A quarterly MDS assessment for Resident 69, dated July 8, 2024, revealed that the resident was cognitively intact, clearly understood, able to clearly understand others, and required assistance with care needs. An admission MDS assessment for Resident 71, dated May 23, 2024, revealed that the resident was cognitively intact, usually understood, usually able to understand others, and required substantial assistance with care needs. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A quarterly MDS assessment for Resident 76, dated July 1, 2024, revealed that the resident was cognitively impaired, understood, able to understand others, and required moderate supervision with care needs. A quarterly MDS assessment for Resident 77, dated July 19, 2024, revealed that the resident was cognitively intact, clearly understood, able to clearly understand others, and required assistance with care needs. A quarterly MDS assessment for Resident 78, dated June 19, 2024, revealed that the resident was cognitively impaired, clearly understood, able to clearly understand others, and required supervision with care needs. A quarterly MDS assessment for Resident 80, dated June 5, 2024, revealed that the resident was cognitively intact, understood, able to understand others, and required assistance with care needs. An annual MDS assessment for Resident 86, dated July 22, 2024, revealed that the resident was cognitively intact, understood, able to understand others, and required assistance with care needs. A quarterly MDS assessment for Resident 89, dated June 25, 2024, revealed that the resident was cognitively intact, understood, able to understand others, and was dependent on staff with care needs. Review of the clinical records for Residents 56, 57, 64, 66, 69, 71, 76, 77, 78, 80, 86 and 89 revealed no documented evidence to indicate that the residents and/or their representative were informed of their rights to develop advance directives, no documented evidence that the residents and/or their representatives were provided the opportunity and assistance to formulate an advance directive, and no documented evidence that advanced directives were addressed with the residents and/or resident representatives periodically throughout their course of stay. Interview with the Social Service Director on August 20, 2024, at 1:41 p.m. confirmed that there was no documented evidence in the clinical records of Residents 56, 57, 64, 66, 69, 71, 76, 77, 78, 80, 86 and 89 that indicated the residents and/or their representatives were informed of their rights to develop advance directives, no documented evidence that the residents and/or their representatives were provided the opportunity and assistance to formulate an advance directive, and no documented evidence that advanced directives were addressed with the residents and/or resident representatives periodically throughout their course of stay. 28 Pa. Code 201.29(a)(d) Resident Rights.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 48809 Based on review of policies, as well as observations and staff interviews, it was determined that the facility failed to provide confidentiality of residents' personal health information during medication administration for one of 45 residents reviewed (Resident 5). Findings include: The facility's policy regarding privacy of health information, dated July 1, 2024, indicated that the facility was to protect the confidentiality of a resident's health information. Observations during medication administration on August 21, 2024, at 7:50 a.m. revealed that Licensed Practical Nurse 1 walked away from the medication cart to take the blood sugar of another resident without securing the computer screen. Resident 5's personal health information was visible on the computer screen, which was facing the hallway and elevator door. Interview with Licensed Practical Nurse 1 on August 21, 2024, at 7:57 a.m. confirmed that she should have covered Resident 5's personal information on the computer screen when leaving the medication cart. Interview with the Assistant Director of Nursing on August 21, 2024, at 11:43 a.m. confirmed that the computer screen with residents' personal health information should have been covered when the nurse was not attending the medication cart. 28 Pa. Code 211.5(b) Clinical Records.

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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. 48809 Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to develop and implement comprehensive care plans that included specific and individualized interventions to address specific care needs for two of 45 residents reviewed (Residents 12, 30). Findings include: The facility's policy regarding care plans, dated July 1, 2024, indicated that a comprehensive person-centered care plan for each resident will be developed that includes measurable objective and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessments. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 12, dated June 19, 2024, revealed that the resident was cognitively intact, understood, could usually understand others, and was receiving physical therapy and occupational therapy. Observations of Resident 12 on August 22, 2024, at 1:00 p.m. revealed that the resident was unable to move her left arm to feed herself, and the resident had a blue splint on left hand and wrist for contractures. Interview with Resident 12 on August 22, 2024, at 1:05 p.m. revealed that the resident had been unable to move her left side since she was four years old due to a brain tumor she had removed. Interview with Certified Occupational Therapist Assistant (COTA) 2 on August 22, 2024, at 1:15 p.m. revealed that Resident 12 had been working with therapy due to left-sided hemiparesis (paralysis on left side of the body). She was working with therapy regarding activities of daily living and contractures in the left hand. There was no documented evidence in Resident 12's clinical record to indicate that a comprehensive care plan was developed that included care for left-sided hemiparesis. Interview with the Assistant Director of Nursing on August 22, 2024, at 1:39 p.m. revealed that Resident 12 was not care planned for left-sided hemiparesis and should have been. An admission MDS assessment for Resident 30, dated July 3, 2024, revealed that the resident was cognitively impaired, usually understood, usually understood others, required assistance with daily care needs, and had a diagnosis of schizophrenia. A nurse's note for Resident 30, dated July 10, 2024, at 4:51 p.m., revealed that the resident was yelling out and hitting himself. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Interdisciplinary Team note for Resident 30, dated July 16, 2024, at 1:46 p.m., revealed that the Interdisciplinary Team including the Registered Nurse Assessment Coordinator, Social Worker, and therapy worker discussed the increased behaviors of Resident 30. A nurse's note for Resident 30, dated July 24, 2024, revealed that the resident was hitting himself and stating, I'm crazy, for a duration of five minutes and making disruptive sounds. There was no documented evidence in Resident 30's clinical record to indicate that a comprehensive care plan was developed that included care for behaviors. Interview with Nursing Home Administrator on August 22, 2024, at 7:59 p.m. confirmed that there was no documented evidence that a care plan was created for Resident 30 for behaviors, and there should have been. 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. 48809 Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that care plans were updated/revised to reflect changes in care needs for three of 45 residents reviewed (Residents 5, 12, 77). Findings include: The facility's policy regarding care plans, dated July 1, 2024 revealed that the care planning coordinator will add minor changes in the resident's status to the existing care plans on a daily basis, and care plans are to be maintained with the current medical record. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 5, dated July 8, 2024, revealed that the resident was cognitively impaired, understood, usually able to understand others, required maximum assistance with care needs, and had a mechanically altered diet. A nurse's note for Resident 5, dated July 25, 2024, at 6:40 a.m., revealed that hospital radiology recommended a level 7, easy-to-chew diet, with thin liquids. Interview with the Director of Rehabilitation on August 21, 2024, at 9:17 a.m. revealed that the recommendations from radiology were followed and Resident 5 was upgraded to thin liquids on the above date. A dietary care plan for Resident 5, dated July 21, 2024, revealed that the resident was to be on low concentrated sweets, no added salt, mechanically soft diet, with nectar thick liquids. There was no documented evidence that the resident's care plan was revised to reflect thin liquids. Interview with the Registered Dietician on August 21, 2024, at 10:59 a.m. confirmed that Resident 5's diet was upgraded from nectar thick liquids to thin liquids on July 25, 2024, and confirmed that the care plan should have been revised to reflect the change from nectar think liquids to thin liquids. A quarterly MDS assessment for Resident 12, dated June 19, 2024, revealed that the resident was cognitively intact, understood, usually able to understand others, required maximum assistance with care needs, and had a history of rejecting care. A nurse's note for Resident 12, dated July 3, 2024, at 8:14 p.m. revealed that the social worker informed the registered nurse that Resident 12's sister was concerned about resident not eating, not participating in activities, and refusing showers. The Social worker offered to have staff reach out when the resident refused care. Interview with the Director of Nursing on August 22, 2024, at 4:48 p.m. confirmed that Resident 12's care plan should have been updated to include contacting her sister for refusals. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A quarterly MDS assessment for Resident 77, dated July 19, 2024, revealed that the resident was cognitively intact, clearly understood, able to clearly understand others, required assistance with care needs, and had an unstageable pressure ulcer (full-thickness pressure injuries in which the base is obscured by slough and/or eschar) and four arterial ulcers (ulcers caused by poor with blood flow to the lower extremities). Physician's orders for Resident 77, dated August 14, 2024, included an order to cleanse the wounds to his left achilles, left heel and left malleolus with normal saline (a sterile solution used for the moistening of wound dressings and wound debridement), apply santyl (a wound debridement treatment), and cover with an abdominal dressing (used for wounds with larger amounts of drainage) and Kerlix (bandage used to secure dressings in place) daily and as needed. A skin integrity care plan for Resident 77, dated May 27, 2024, indicated that the resident had a Stage 2 pressure ulcer to his right buttock. A nursing note, dated August 15, 2024, at 3:07 p.m. revealed that the resident's skin was assessed and the wound on the buttocks was healed. There was no documented evidence that the resident's skin integrity care plan was revised to reflect that the Stage 2 pressure ulcer to his buttocks was healed, and no documented evidence to reflect that the skin integrity care plan was revised to include the wound to his left malleolus. Interview with the Director of Nursing on August 22, 2024, at 4:50 p.m. confirmed that Resident 77's Stage 2 pressure ulcer to his right buttocks was healed, the care plan should have been revised to reflect the area was resolved, and the care plan should have been revised to include the resident's wound to his left malleolus. 28 Pa. Code 211.12(d)(5) Nursing Services.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48941 Based on review of Pennsylvania's Nursing Practice Act, facility policies, and clinical records, as well as staff interviews, it was determined that the facility failed to obtain physician's orders for pacemaker checks for one of 45 resident reviewed (Resident 78). 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. The facility's policy regarding pacemaker rate checks, dated July 1, 2024, indicated that upon the resident admission with, or insertion of, a cardiac pacemaker, the licensed nurse will gather pertinent information and complete the cardiac pacemaker data sheet, and it will be kept in the resident's medical record. The licensed staff will obtain an order for routine pacemaker checks, and the checks will be completed per manufacture's recommendations. Documentation of any checks and services provided will be maintained in the nurse's notes. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 78, dated June 19, 2024, revealed that the resident was cognitively impaired, clearly understood, able to clearly understand others, required supervision with care needs, and had diagnoses that included congestive heart failure (the heart cannot pump blood well enough to meet the body's needs) and cardiac pacemaker (a surgically-implanted, small battery-powered device to manage irregular heartbeats or heart failure). A care plan for Resident 78, dated July 18, 2023, indicated that the resident had a cardiac pacemaker and was to have pacemaker checks (to check if pacemaker is functioning properly) done as per physician's order. There was no documented evidence in Resident 78's clinical record of a physician's order for pacemaker checks per facility policy and per care plan, and no documented evidence that any pacemaker checks had been completed since his admission to the facility. Interview with the Nursing Home Administrator on August 21, 2024, at 11:22 a.m. confirmed that there was no documented evidence in Resident 78's clinical record that pacemaker checks were being done as per facility policy and resident care plan. Interview with the Registered Nurse Assessment Coordinator (RNAC- a registered nurse who is responsible for completing MDS assessments and who is often involved in the development of care plans) on August 21, 2024, at 1:42 p.m. confirmed that Resident 78 was admitted to the facility on [DATE], and was scheduled to have a pacer clinic appointment on March 22, 2023 but it was missed. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 48809 Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that upon discharge from the facility, a discharge summary, including a recapitulation of the resident's stay, was completed for one of three discharged residents reviewed (Resident 104). Findings include: Admission diagnoses for Resident 104, dated June 25, 2024, revealed that the resident was admitted to the facility with diagnoses that included diabetes mellitus, hypertension (high blood pressure), atrial fibrillation (irregular heartbeat), and cellulitis (bacterial infection of the skin). A nurse's note for Resident 104, dated June 29, 2024, revealed that the resident left the facility against medical advice (AMA). As of August 22, 2024, there was no documented evidence that a discharge summary that included a recapitulation of the resident's stay was completed for Resident 104. Interview with Registered Nurse Assessment Coordinator (RNAC) on August 22, 2024, at 6:35 p.m. confirmed that a discharge summary with a recapitulation of the resident's stay was not completed for Resident 104. 28 Pa. Code 211.5(d) Clinical Records.

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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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 48941 Based on a review of clinical records, as well as resident and staff interviews, it was determined that the facility failed to ensure that restorative nursing programs to maintain or improve physical abilities were provided as ordered and/or care planned for one of 45 residents reviewed (Resident 56). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 56, dated July 10, 2024, revealed that the resident was cognitively intact, clearly understood, able to clearly understand others, required supervision with care needs, had a fall without injury since prior assessment, and had a diagnosis of Cerebral Palsy. A care plan for Resident 56, initiated July 5, 2023, indicated that he had an activities of daily living deficit related to impaired balance. A care plan intervention for Resident 56, initiated on July 12, 2023, indicated that the resident was on a restorative ambulation program with a goal to walk 100 feet with a front-wheeled walker and non-skid footwear with supervision twice a day (between 7:00 a.m. and 3:00 p.m.) and (between 3:00 p.m. and 11:00 p.m). The restorative ambulation was to be documented on the activity of daily living flowsheet. A physical therapy discharge evaluation for Resident 56, dated April 12, 2024, indicated that the resident was on a restorative nursing program for ambulation 100 feet times two with supervision and front-wheeled walker. An interview with Resident 56 on August 19, 2024, at 12:18 p.m. revealed that he was care planned to receive restorative ambulation from the staff when discharged from therapy and indicated that he does not get walked as much as he should. He indicated that he has been care planned since July 2023 to walk with the staff after being discharged from therapy and they are not doing it. Review of Resident 56's restorative ambulation documentation from June 15, 2024, through August 20, 2024, as well as the clinical record, revealed no documented evidence that the restorative ambulation program was completed as per therapy recommendations and as per care plan between 7:00 a.m. and 3:00 p.m. for the following dates: June 15, 16, 17, 20, 21, 23, 28, 29, 30, 2024; July 2, 5, 6, 7, 9, 11, 12, 17, 19, 20, 21, 22, 23, 24, 25, 28, 29, 30, 31, 2024; and August 12, 18, 19, 20, 2024. Review of Resident 56's restorative ambulation documentation from June 15, 2024, through August 20, 2024, as well as the clinical record, revealed no documented evidence that the restorative ambulation program was completed as per therapy recommendations and as per care plan between 3:00 p.m. and 11:00 p.m. for the following dates: June 15, 21, 23, 27, 2024; July 3, 5, 7, 13, 19, 24, 29, 2024; and August 3, 9, 10, 15, 16, 20, 2024. An interview with the Nursing Home Administrator on August 21, 2024, at 2:27 p.m. confirmed that there was no documented evidence that Resident 56's restorative ambulation program was completed as per therapy recommendations and as per care plan on the dates and times listed above. (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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(d)(3)(5) Nursing Services.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 48809 Based on a review of clinical records, facility policy review, and resident and staff interviews, it was determined that the facility failed to ensure that residents were provided with showers as scheduled for one of 45 residents reviewed (Resident 12). Findings include: A facility policy for resident personal care, dated July 1, 2024, indicated that residents will be provided showers and oral care as per request or as per facility schedule protocols. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 12, dated June 19, 2024, indicated that the resident was understood, could usually understand others, cognitively intact, and dependent on staff for personal care needs. A care plan for Resident 12, dated March 27, 2024, indicated that the resident preferred to have showers every Tuesday and Saturday during the second shift and to have oral care completed twice a day. Review of bathing documentation for Resident 12 from August 13, 2024, through August 22, 2024, indicated that the resident did not receive a shower during that time. There was no documented evidence that the resident was offered and refused showers twice weekly as per her care plan. A review of oral care documentation for Resident 12 from August 13, 2024, through August 22, 2024, revealed that the resident only received oral care three times. There was no documented evidence that the resident was offered and refused the oral care twice a day per her care plan. Interview with Resident 12's sister on August 21, 2024, at 3:56 p.m. revealed that there were times when the resident was not clean, had greasy hair, dirty clothes, and her teeth were not brushed, so she cleaned the resident herself. She was concerned that there was not enough staff to provide her with the proper care, so she comes in and does it herself. Interview with the Assistant Director of Nursing on August 22, 2024, at 3:44 p.m. confirmed that there was no documented evidence that Resident 12 was offered or refused showers twice a week, and no documented evidence that oral care was offered or refused from August 13, 2024, to August 22, 2024. 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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 42079 Based on a review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to follow a physician's recommendations for one of 45 residents reviewed (Residents 13) resulting in a deterioration of the wound with increased size, and there was no documented evidence that physician's orders were followed for two of 45 residents reviewed (Residents 12, 86). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 13, dated June 29, 2024, revealed that the resident was understood, could understand others, was cognitively intact, required assistance from staff for care needs, and had a Stage IV pressure ulcer (a wound with full-thickness skin loss that extends through into the muscle, exposing the bone, tendon, or joint) upon admission. A wound healing consult for Resident 13 (outside the facility), dated July 5, 2024, revealed that the resident had a Stage 4 pressure injury with bone exposed on the sacral area. Recommendations included a high protein diet, a low air loss mattress, frequent scheduled repositioning, a wound vacuum on the wound (uses negative pressure to help wounds heal faster), and a follow-up appointment to be scheduled in four to six weeks. Until the wound vacuum could be obtained, it was recommended that the resident receive 15 milliters (ml) of Dakins (a solution used to clean pressure ulcers) irrigation to the wound and patted dry, fluffed Dakins moistened gauze into the wound space to address all undermining areas, then cover with a dry gauze and secure with tape to be changed daily or as needed. The order for the wound vacuum was to clean the area with soap and water, pat dry, then irrigate the wound with 15 ml of Dakins, pat dry, apply skin prep to the periwound (the skin that surrounds the wound), cut and apply black granufoam (specialized foam dressing) to fit inside of the wound and depth, seal the dressing and bridge the dressing (technique can be used to prevent pressure to the area) to the left or right hip to keep pressure off the area, and to run at 125 millimeters of mercury (mmHg) continuous suction. The wound vacuum dressing was to be changed once a week or as needed. Physician's orders for Resident 13, dated July 6, 2024, only included orders for the resident to have a Dakins wet-dry dressing. Irrigate the wound with 15 ml of Dakins and pat dry, fluff Dakins moistened gauze into the wound space to address all areas, then cover with a dry gauze and secure with tape changed daily or as needed; however, there was no documented evidence in the clinical record to indicate that the wound vacuum machine and treatment was ordered, and no documented evidence to indicate that the follow-up appointment for four to six weeks was made. A wound consult for Resident 13 (outside of the facility) dated July 23, 2024, revealed that the wound was a Stage 4 with stalled wound healing and measured 3 centimeters (cm) by 2 cm with a depth of 1 cm. There was a 0.4 cm undermining from 11 o'clock to 1 o'clock. The exposed bone was palpable (able to be touched). A wound consult report (conducted within the facility) for Resident 13, dated July 31, 2024, revealed that the resident was not seen or evaluated by the wound team because she was out at dialysis. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A wound consult (conducted within the facility) for Resident 13, dated August 7, 2024, revealed that the resident was not seen or evaluated by the wound team because she was out at dialysis. The wound consult recommended that she be referred to the local wound center due to conflicting schedules; however, there was no documented evidence in the clinical record to indicate that the referral was made. A registered nurse progress note and wound assessment for Resident 13, dated August 21, 2024, revealed that the Stage 4 sacral wound measured 4 centimeters (cm) by 2.5 cm with a depth of 1.5 cm with undermining. A review of the clinical record for Resident 13 revealed no documented evidence that a wound vacuum was ordered, applied, or that wound consultant recommendations were followed for negative pressure wound therapy. There was no documented evidence that the resident returned to the outside wound clinic in four to six weeks for follow-up as recommended, and there was no documented evidence that an outside wound clinic appointment was scheduled until August 22, 2024, after it was brought to the facility's attention by the surveyor. Interview with the Assistant Director of Nursing on August 22, 2024, at 1:30 p.m. revealed that she spoke with the wound clinic and Resident 13 was to follow up with them on August 7, 2024; however, Resident 13 was a no-call no-show for that appointment and was not seen. Interview with the Director of Nursing on August 22, 2024, at 10:49 a.m. and 1:22 p.m. confirmed that the facility failed to follow through with orders for a wound vacuum, failed to ensure that the resident went to a follow-up wound appointment, and failed to make an additional referral to the wound clinic for ongoing treatment and evaluation due to scheduling conflicts. She also confirmed that Resident 13's wound was last assessed on July 23, 2024, and was not provided the wound vacuum as recommended or weekly wound assessments, and the wound declined. The facility's policy for personal care, dated July 1, 2024, indicated that the nursing assistant will observe all areas of the resident's skin and indicate any abnormalities or changes, and the nurse will address any findings in the clinical record and appropriate interventions will be initiated. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 12, dated June 19, 2024, revealed that the resident was cognitively intact, understood, could usually understand others, and required maximum assistance from staff for care. A physician's order for Resident 12, dated March 19, 2024, included an order for weekly skin checks to be completed and documented in the resident's clinical record. A review of the clinical record for June and July for Resident 12 revealed no documented evidence that skin checks were being completed for June and July. An interview with the Assistant Director of Nursing on August 22, 2024, at 3:43 p.m. confirmed that there was no documented evidence that skin checks were being completed for Resident 12. An annual MDS assessment for Resident 86, dated July 22, 2024, revealed that the resident was cognitively intact, understood, could understand others, required maximum assistance from staff for care, and had a foley catheter (a tube placed in the bladder and drains urine into a collection bag). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A physician's order for documentation on urinary output, dated March 1, 2024, revealed that the total amount of urine output in the bag was to be documented in the clinical record each shift. A review of the clinical record for March 1, 2024, to August 20, 2024, for Resident 86 revealed no documented evidence that the urine output was documented in the clinical record each shift. An interview with the Director of Nursing on August 20, 2024, at 2:37 p.m. confirmed that there was no documented evidence that urinary output was being documented and should have been. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assist a resident in gaining access to vision and hearing services. 48941 Based on clinical record reviews and staff interviews, it was determined that the facility failed to follow physician's orders and residents' requests for ophthalmology appointments for two of 45 residents reviewed (Residents 69, 87). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 69, dated July 10, 2024, revealed that the resident was cognitively intact, clearly understood, able to clearly understand others, and required supervision with care needs. An interview with Resident 69 on August 19, 2024, at 11:44 a.m. revealed that she wanted to go to the eye doctor and that Senior Life was not scheduling it. She indicated that it had been scheduled, but she did not go due to a screw up with Senior Life and transportation. She voiced that she was nearly blind, could not see, and wanted to be seen by the eye doctor. The Social Service Director received an email from the local Senior Services office on July 18, 2024, regarding Resident 69's vision exam. They had left messages with Senior Life about rescheduling the vision exam, but there had been no return call from them. The Social Service Director then sent an email to Senior Life on July 18, 2024, regarding Resident 69's vision exam needing to be rescheduled. There was no documented evidence in Resident 69's clinical record to indicate that any further attempts to reschedule the vision exam had been made since the July 18, 2024, email to Senior Life. Interview with the Social Service Director on August 22, 2024, at 8:30 p.m. confirmed that there had been no further follow-ups or attempts to communicate with Senior Life to reschedule Resident 69's vision exam. An annual MDS assessment for Resident 87, dated July 2, 2024, revealed that the resident was cognitively impaired, usually understood, able to sometimes understand others, required assistance with care needs, and had a diagnosis of diabetes. Physician's orders for Resident 87, dated April 4, 2024, indicated that the resident was to be scheduled for a vision exam with 360 services. Documentation provided by the Nursing Home Administrator, dated April 4, 2024, at 5:52 p.m. revealed that an email was sent by Registered Nurse 3 to the Social Service Director informing her that Resident 87 was ordered to have a vision exam with 360 services; however, there was no documented evidence in the resident's clinical record that the vision exam was scheduled. Interview with the Nursing Home Administrator on August 21, 2024, at 8:46 a.m. confirmed that there was no documented evidence in Resident 87's clinical record that a vision exam was scheduled with 360 services. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 211.12(d)(3)(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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 42079 Based on review of clinical records, as well as resident and staff interviews, it was determined that the facility failed to provide necessary treatment and services for a Stage 4 pressure ulcer for one of 45 residents reviewed (Resident 13) resulting in a deterioration of the wound. Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 13, dated June 29, 2024, revealed that the resident was understood, could understand others, was cognitively intact, required assistance from staff for care needs, and had a Stage IV pressure ulcer (a wound with full-thickness skin loss that extends through into the muscle, exposing the bone, tendon, or joint) upon admission. A wound healing consult for Resident 13 (outside the facility), dated July 5, 2024, revealed that the resident had a Stage 4 pressure injury with bone exposed on the sacral area. Recommendations included a high protein diet, a low air loss mattress, frequent scheduled repositioning, a wound vacuum on the wound (uses negative pressure to help wounds heal faster), and a follow-up appointment to be scheduled in four to six weeks. Until the wound vacuum could be obtained, it was recommended that the resident receive 15 milliters (ml) of Dakins (a solution used to clean pressure ulcers) irrigation to the wound and patted dry, fluffed Dakins moistened gauze into the wound space to address all undermining areas, then cover with a dry gauze and secure with tape to be changed daily or as needed. The order for the wound vacuum was to clean the area with soap and water, pat dry, then irrigate the wound with 15 ml of Dakins, pat dry, apply skin prep to the periwound (the skin that surrounds the wound), cut and apply black granufoam (specialized foam dressing) to fit inside of the wound and depth, seal the dressing and bridge the dressing (technique can be used to prevent pressure to the area) to the left or right hip to keep pressure off the area, and to run at 125 millimeters of mercury (mmHg) continuous suction. The wound vacuum dressing was to be changed once a week or as needed. Physician's orders for Resident 13, dated July 6, 2024, only included orders for the resident to have a Dakins wet-dry dressing. Irrigate the wound with 15 ml of Dakins and pat dry, fluff Dakins moistened gauze into the wound space to address all areas, then cover with a dry gauze and secure with tape changed daily or as needed. A wound consult for Resident 13 (outside of the facility), dated July 23, 2024, revealed that the wound was a Stage 4 with stalled wound healing and measured 3 centimeters (cm) by 2 cm with a depth of 1 cm. There was a 0.4 cm undermining from 11 o'clock to 1 o'clock. The exposed bone was palpable (able to be touched). A wound consult report (conducted within the facility) for Resident 13, dated July 31, 2024, revealed that the resident was not seen or evaluated by the wound team because she was out at dialysis. A wound consult (conducted with in the facility) for Resident 13, dated August 7, 2024, revealed that the resident was not seen or evaluated by the wound team because she was out at dialysis. The wound consult recommended that she be referred to the local wound center due to conflicting schedules. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A review of the clinical record revealed that as of August 21, 2024, there was no documented evidence in the clinical record to indicate that Resident 13's Stage 4 sacral wound had been assessed by a registered nurse or the wound team since July 23, 2024; no documented evidence that a wound vacuum was ordered, applied, or that wound dressing recommendations were followed for the negative pressure wound therapy; no documented evidence that the resident returned to the outside wound clinic in four to six weeks for a follow-up as recommended; and no documented evidence that the recommendation for an outside wound clinic appointment was made due to conflicting schedules until it was brought to the facility's attention by the surveyor. A registered nurse progress note and wound assessment for Resident 13, dated August 21, 2024, revealed that the Stage 4 sacral wound measured 4 centimeters (cm) by 2.5 cm with a depth of 1.5 cm with undermining. Observations and interviews with Resident 13 on August 22, 2024, at 6:17 p.m. revealed that she was awake, eating, and lying in bed. She was positioned on her left side with a wedge toward the window. She stated that she received wound changes daily and was told that the wound was deep. She was comfortable at that time without the additional positional pressure on the wound area. She stated that she finds the wound to be very painful and very uncomfortable when she has to sit in a chair at dialysis and she is unable to offload the pressure or reposition. Interview with the Assistant Director of Nursing on August 22, 2024, at 1:30 p.m. revealed that she spoke with the wound clinic and Resident 13 was to follow up with them on August 7, 2024; however, Resident 13 was a no-call no-show for that appointment and was not seen. Interview with the Director of Nursing on August 22, 2024, at 10:49 a.m. and 1:22 p.m. confirmed that the facility failed to obtain a wound vacuum, failed to ensure that the resident went to a follow-up wound appointment, and failed to make an additional referral to the wound clinic for ongoing treatment and evaluation due to scheduling conflicts. She also confirmed that Resident 13's wound had not been assessed since July 23, 2024, was not provided the wound vacuum or weekly wound assessments and the wound declined. 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 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. 42079 Based on review of clinical records and facility investigation reports, as well as staff interviews, it was determined that the facility failed to complete safety assessments for two of 45 residents reviewed (Residents 13, 51) who used an air mattress. Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 13, dated June 29, 2024, revealed that the resident was understood, could understand others, was cognitively intact, required assistance from staff for care needs, and had a Stage IV pressure ulcer (a wound with full-thickness skin loss that extends through into the muscle, exposing the bone, tendon, or joint) upon admission. A care plan for Resident 13, dated December 22, 2024, revealed that the resident had a Stage IV pressure ulcer. A wound healing consult completed outside of the facility for Resident 13, dated July 5, 2024, revealed that the resident had a Stage 4 pressure injury with bone exposed on the sacral area. The wound consult recommended a low air loss mattress and frequent scheduled repositioning. Physician's orders for Resident 13, dated July 6, 2024, indicated that the facility was to obtain a low air loss mattress. Observations on August 19, 2024, at 12:45 p.m. and August 22, 2024, at 6:17 p.m. revealed that Resident 13 was lying in bed and the bed was equipped with an air mattress; however, there was no documented evidence that the use of an air mattress was assessed for potential safety hazards prior to being placed on Resident 13's bed. A significant change MDS Resident 51, dated July 10, 2024, revealed that the resident was understood, understood others, was severely cognitively impaired, was dependent on staff for his daily care needs, had impairment on one side of his body, and had unhealed Stage 3 (full thickness skin loss into the lower layers of skin) and Stage 4 pressure ulcers. Observations on August 19, 2024, at 11:55 a.m. revealed that Resident 51 was lying in bed and the bed was equipped with an air mattress; however, there was no documented evidence that the use of an air mattress was assessed for potential safety hazards prior to being placed on Resident 51's bed. A nurses' note for Resident 51, dated July 21, 2024, at 4:53 p.m., revealed that the resident had a fall from the bed due to leaning on his left side, and the air mattress was forcing him to the edge of the bed. The bed enablers were recently removed, and the resident was unable to reposition himself, resulting in a fall from the bed. There was no injury noted. Interview with the Director of Nursing on August 22, 2024, at 6:27 p.m. confirmed that there were no assessments for potential safety hazards prior to the air mattresses being placed on the resident's beds and there should have been. (continued on next page)

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	395985	A. Building B. Wing	08/22/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(d)(3)(5) Nursing Services.

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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. 41233 Based on review of facility policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to address a change in urine status for one of 45 residents (Resident 12), and failed to provide proper care for indwelling urinary catheters for one of 45 residents reviewed (Resident 67). Findings include: A diagnosis list for Resident 12, dated March 19, 2024, revealed that the resident had a history of chronic urinary tract infections (UTI's). A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs), dated June 19, 2024, revealed that the resident was cognitively intact, required extensive assistance from staff for daily care tasks, and had an indwelling urinary catheter (a flexible tube inserted and held in the bladder to drain urine). A review of the clinical record for Resident 12 revealed that on August 15, 2024, the resident had 300 milliliters (ml) of blood-tinged urine in her foley catheter collection bag. A nursing note for Resident 12, dated August 18, 2024, at 7:40 p.m., revealed that the resident's sister spoke with a licensed practical nurse regarding the resident having tea-colored urine in her foley collection bag, and new orders were received from the doctor for a urinalysis to determine if the resident had a UTI. A nurse's note dated, August 21, 2024, at 1:01 p.m. revealed that Resident 12 began a new order for 400 mg of Cefpodoxime (an antibiotic) every 12 hours for seven days for a UTI. Interview with the Director of Nursing on August 22, 2024, at 4:49 p.m. confirmed that Resident 12 should have been assessed on August 15, 2024, when there was 300 ml of blood tinged urine in her foley bag. The facility's policy regarding urinary catheter care, dated July 1, 2024, revealed that the catheter tubing and drainage bag were to be kept off the floor and in a dignity bag. A significant change MDS assessment for Resident 67, dated June 10, 2024, revealed that the resident was severely cognitively impaired; had diagnoses that included dementia, down syndrome, and urinary retention; and had an indwelling catheter. Observations of Resident 67 on August 21, 2024, at 9:46 a.m. revealed that the resident was lying in bed with the indwelling catheter tubing and drainage bag lying on the floor underneath his bed with no dignity bag in place. Interview with Nurse Aide 4 on August 21, 2024, at 9: 50 a.m. confirmed that Resident 67's indwelling catheter tubing and drainage bag should not be on the floor, and that it should be in a dignity bag. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Assistant Director of Nursing/Infection Control on August 21, 2024, at 9:55 p.m. confirmed that the catheter tubing and drainage bag should not be on the floor, and that it should be in a dignity bag. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 48809 Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to provide aggressive hydration of 4 liters a day recommended by urology for one of 45 residents reviewed (Resident 12). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 12, dated June 19, 2024, indicated that the resident was cognitively intact, required assistance from staff for her daily care needs, and had a medical diagnosis of chronic urinary tract infections (UTI). A urology consult for Resident 12, dated July 17, 2024, included a recommendation for the resident to have aggressive hydration of 4 liters (4000 milliliters) a day. Physician's orders for Resident 12, dated July 17, 2024, included an order for the resident to have 4 liters of water a day and to have the total water intake documented every 6 hours (at 9:00 a.m., 3:00 p.m., 9:00 p.m., and 3:00 a.m.). A review of the clinical records for Resident 12 revealed a total fluid intake of 1162 milliliters (mL) on August 20, 2024; 670 mL on August 19, 2024; 1640 mL on August 18, 2024; 1255 mL on August 17, 2024; 1640 mL on August 16, 2024; 1020 mL on August 15, 2024; 490 mL on August 14, 2024; and 620 mL on August 13, 2024. There was no documented evidence that Resident 12 refused or was receiving the ordered 4 liters of fluid a day. An interview with the Nursing Home Administrator on August 22, 2024, at 4:55 p.m. confirmed that there was no documented evidence that Resident 12 refused or was receiving the ordered 4 liters of fluid a day and there should have been. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 42079 Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to have sufficient nursing staff to provide and document care as scheduled for two of 45 residents reviewed (Residents 12, 19). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 12, dated June 19, 2024, indicated that the resident was understood and could usually understand others, was cognitively intact, and was dependent on staff for personal care needs. A care plan for Resident 12, dated March 27, 2024, indicated that the resident preferred to have showers every Tuesday and Saturday during the second shift, and to have oral care completed twice a day. Review of bathing documentation for Resident 12 from August 13, 2024, through August 22, 2024, indicated that the resident did not receive a shower during that time. There was no documented evidence that the resident was offered and refused showers twice weekly as per her care plan. A review of oral care documentation for Resident 12 from August 13, 2024, through August 22, 2024, revealed that the resident only received oral care three times. There was no documented evidence that the resident was offered and refused the oral care twice a day per her care plan. Interview with Resident 12's sister on August 21, 2024, at 3:56 p.m. revealed that there were times the resident was not clean, her hair was greasy, her clothes were dirty, and her teeth were not brushed, so she cleaned the resident herself. She is concerned that there is not enough staff to provide her with the proper care, so she comes in and does it herself. Interview with the Assistant Director of Nursing on August 22, 2024, at 2:22 p.m. confirmed that there was no documented evidence that Resident 12 was offered or refused showers twice a week, and no documented evidence that oral care was offered or refused from August 13, 2024, to August 22, 2024. Interviews with direct care staff throughout the survey revealed that there is not enough staff to complete all tasks for residents. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 19, dated July 29, 2024, revealed that the resident was understood, could understand, was cognitively impaired, and was totally dependent on two staff for assistance with bed mobility and transfers. The current care plan for Resident 19 revealed that she was at risk for falls related to being non-ambulatory. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations on August 19, 2024, at 1:13 p.m. revealed that Resident 19 was sitting and activated her call bell. Resident 19 stated that she needed changed. Nurse Aide 5 entered the room at 1:13 p.m. and told the resident, Okay, in one minute, and turned the call bell off. Continued observations revealed that Resident 19 activated her call bell again at 1:55 p.m. Resident 19 said she was wet and needed to be changed, and said she takes a fluid pill that makes her urinate frequently. Nurse Aide 5 changed her shirt but did not provide incontinence care or change the resident's soiled brief. Interview with Nurse Aide 5 at 1:59 p.m. revealed that Resident 19 was a two-person assist with a full body lift. She reported that she had already changed Resident 19 before getting her up for lunch and that there were other residents that still needed care. There were five nurse aides on the floor for over 55 residents and not enough staff to provide the care. Interview with the Nursing Home Administrator on August 22, 2024, at 3:10 p.m. confirmed that the call bell wait was not appropriate, and that the facility has been trying to make staff accountable for breaks and lunches. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 48809 Based on review of clinical records and staff interviews, it was determined that the facility failed to ensure the accountability of controlled medications for one of 45 residents reviewed (Resident 86). Findings include: An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 86, dated July 22, 2024, indicated that the resident was cognitively intact, required assistance from staff for all daily care needs, and had pain rated as a 6 on a scale of 1 to 10 (with 1 being mild and 10 being the worst) during the assessment period. Physician's orders for Resident 86, dated December 26, 2023, included an order for the resident to receive one 10-325 milligram (mg) tablet of oxycodone/Tylenol (a combination controlled narcotic pain medication) between the hours of 12:00 a.m. and 4:00 a.m. as needed. Review of Resident 86's controlled drug record (used to keep count of narcotic medication) for April and May 2024 revealed that staff signed out one table of hydrocodone/Tylenol on the controlled drug log on April 7, 2024, at 3:34 a.m.; April 14, 2024, at 3:34 a.m.; April 24, 2024 at 2:10 a.m.; May 6, 2024, at 1:00 a.m.; and May 8, 2024 at 2:15 a.m. However, there was no indication on the resident's Medication Administration Record for April and May 2024 that the narcotic medication was administered to the resident on those dates and times. Interview with the Director of Nursing on August 22, 2024, at 10:06 a.m. confirmed that there was no documented evidence that the narcotic pain medication was administered to Resident 86 on those dates and times and that the nurses are expected to sign the MAR when they administer a pain medication. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 48809 Based on review of policy and clinical records, as well as staff interviews, it was determined that the facility failed to respond timely to a pharmacy recommendation for two of 45 residents reviewed (Residents 30, 89). Findings include: A facility policy for medication regimen review, dated July 1, 2024, revealed that the attending physician should document in the resident's health record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 30, dated July 3, 2024, revealed that the resident was cognitively impaired, required total care from staff, and was medicated with a hypotensive (a medication to treat low blood pressure). A pharmacy consultant note for Resident 30, dated June 27, 2024, revealed that the pharmacist recommended that the physician reassess the prescription for midodrine scheduled medication times. It was not to be given after 6:00 p.m., and it was scheduled to be given at 8:00 p.m. As of August 22, 2024, there was no documented evidence the pharmacist medication regimen review was addressed by the physician. An interview with the Director of Nursing on August 22, 2024, at 7:24 p.m. confirmed that there was no documented evidence the pharmacist medication regimen review was addressed by the physician. A quarterly MDS assessment for Resident 89, dated June 25, 2024, revealed that the resident was cognitively intact, was dependent on staff for daily care needs, and was medicated with anti-anxiety medication. A pharmacy consultant note for Resident 89, dated June 23, 2024, revealed that the pharmacist recommended that the physician review the orders for using the medications Citalopram (a medication used to treat depression) and Cilostazol (a mediation used to treat blood clots) together, and to stop the order for nystatin (a medication used to treat fungal infections). There was no documented evident that pharmacist medication regimen review was addressed by the physician. A pharmacy consultant note for Resident 89, dated July 24, 2024, revealed that that pharmacist recommended that a lipid panel (a test to measure the amount of fats in the blood) be completed for the resident the next lab day. There was no documented evidence that the pharmacist medication regimen review was addressed by the physician. An interview with the Assistant Director of Nursing on August 22, 2024, at 3:04 p.m. confirmed that there was no documented evidence that the pharmacist medication regimen review was addressed by the physician. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 211.9(f)(3) Pharmacy Services.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 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 residents were free from unnecessary psychotropic medications for one of 45 residents reviewed (Resident 87). Findings include: The facility's policy regarding psychotropic medications (any medication that affects brain activities associated with mental processes and behavior), dated July 1, 2024, indicated that all residents receiving psychoactive medications will have their behaviors and effectiveness of interventions (pharmacological and non-pharmacological) monitored and documented. Nurses will document on the following each shift: number of behavioral episodes, specific non-medication interventions used, and outcomes of interventions including individualized non-pharmacological approaches. An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 87, dated July 2, 2024, revealed that the resident was cognitively impaired, usually understood, able to sometimes understand others, required minimal assistance with care needs, had verbal and other behaviors, and had diagnoses that included Alzheimer's disease, dementia with agitation, and anxiety. Physician's orders for Resident 87, dated May 13, 2024, included an order for medication monitoring of anti-anxiety medication every shift to monitor for side effects of medications and documentation of non-pharmacological interventions. Physician's orders for Resident 87, dated June 7, 2024, included an order for the resident to receive 0.5 milligrams (mg) of Ativan (a psychotropic medication used to treat anxiety) every eight hours as needed for anxiety. Review of the Medication Administration Record (MAR) for Resident 87 for June 2024 revealed that the resident was administered 0.5 mg of Ativan on the following dates and times: June 12 at 4:57 p.m., June 19 at 11:05 p.m., and June 20 at 7:45 p.m. There was no documented evidence that non-pharmacological behavioral interventions were attempted prior to administering Ativan on the above stated dates and times. Physician's orders for Resident 87, dated July 15, 2024, included an order for the resident to receive 0.5 mg of Xanax (a psychotropic medication used to treat anxiety) every eight hours as needed for anxiety and/or agitation. Physician's orders for Resident 87, dated August 5, 2024, included an order for the resident to receive 0.5 mg of Xanax every eight hours as needed for anxiety and/or agitation. Physician's orders for Resident 87, dated August 18, 2024, included an order for the resident to receive 0.5 mg of Xanax every eight hours as needed for anxiety and/or agitation. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Medication Administration Record (MAR) for Resident 87 for July and August 2024 revealed that the resident was administered 0.5 mg of Xanax on the following dates and times: July 23 at 4:37 a.m., July 24 at 12:19 p.m., July 25 at 2:31 p.m., August 6 at 5:56 p.m., August 7 at 6:47 p.m., August 12 at 5:04 p. m., August 16 at 6:24 a.m., and August 18 at 6:25 a.m. and 8:58 p.m. There was no documented evidence that non-pharmacological behavioral interventions were attempted prior to administering Xanax on the above stated dates and times. Interview with the Registered Nurse Assessment Coordinator on August 20, 2024, at 3:24 p.m. confirmed that non-pharmacological interventions should have been attempted prior to the administration of Ativan and Xanax to Resident 87 on the above stated dates and times. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 41233 Based on review of manufacturer's instructions, facility policies, and clinical records, as well as observations and staff interviews, it was determined that the facility failed to maintain a medication error rate of less than five percent. Findings include: The facility's policy regarding medication administration procedures, dated July 1, 2024, indicated that medications were to be administered in a safe and timely manner, and medications listed as should not crush should not be crushed unless the physician writes otherwise, and manufacturer's instructions were to be followed unless otherwise directed. Observations during medication administration on August 21, 2024, revealed that two medication administration errors were made during 30 opportunities for error, resulting in a medication administration error rate of 6.67 percent. The manufacturer's instructions for Trelegy Ellipta (a combination medicine that is inhaled to treat chronic obstructive pulmonary disease (COPD) and asthma), dated May 2024, indicated that after inhalation, the resident was to rinse their mouth with water without swallowing to help reduce the risk of fungal infections. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 68, dated June 13, 2024, revealed that the resident was severely cognitively impaired and had diagnoses that included seizures. Physician's orders for Resident 68, dated March 13, 2024, included orders for the resident to be given a 250 mg tablet of Depakote-delayed release (medication used to treat seizures, migraines and bipolar disorder) daily in the a.m., and one inhalation of Trelegy Ellipta 100-62. 5-25 mcg (micrograms) daily in the a.m. Observations during medication administration on August 21, 2024, at 9:09 a.m. revealed that Licensed Practical Nurse (LPN) 6 crushed all of Resident 68's morning medications, including the Depakote, and administered them in applesauce. She then administered one inhalation of Trelegy Ellipta; however, the resident did not rinse and spit and the nurse did not instruct the resident to swish and spit after the administration. Interview with LPN 6 at that time revealed that the resident would not take pills whole, and she confirmed that she did not direct the resident to rinse his mouth. She stated that he always refused in the past. LPN 6 further confirmed that there was a do not crush order for the Depakote and that there was no documentation to indicate the resident routinely refused to rinse his mouth after using the inhaler. Interview with Registered Nurse Supervisor 7 on August 22, 2024, at 9:50 a.m. confirmed that Depakote delayed release tablet should not have been crushed, and that the resident should have been directed to rinse his mouth after using the inhaler. A thorough review of Resident 68's clinical record by RN Supervisor 7 confirmed that there was no documentation to indicate that the physician was aware the resident would not take pills whole and no documented evidence that he was refusing to rinse out his mouth after using the inhaler. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director Of Nursing on August 22, 2024, at 10:45 confirmed that Resident 68's Depakote delayed release tablet should not have been crushed, and that the physician should have been notified that the resident refused to rinse his mouth after using the inhaler. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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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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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 41233 Based on observations and staff interviews, it was determined that the facility failed to ensure that controlled medications were stored in a separately locked, permanently affixed compartment in one of two medication rooms reviewed (second floor), and failed to date an insulin pen with the date it was opened (third floor long hall medication cart). Findings include: A facility policy titled Storage and Expiration Dating of Medications and Biologicals, dated July 1, 2024, revealed that the facility will maintain narcotics stored in the medication room locked refrigerator in a separately locked permanently affixed compartment, and that upon using an insulin pen for the first time, it must be dated with the opened date. Observations in the second floor medication room on August 21, 2024, at 9:50 am. revealed that there was a narcotic storage box containing two bottles of 2 mg/ml liquid Ativan (a controlled medication used to treat anxiety). The storage box was attached to the glass shelf; however, the shelf was not permanently affixed to the inside of the refrigerator. An interview with the Assistant Director of Nursing at that time confirmed that the narcotic storage box containing the liquid Ativan should have been permanently affixed to the inside of the medication room refrigerator, and it was not. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 19, dated July 29, 2024, revealed that the resident was understood and understood others, was cognitively intact, was dependent on staff for her daily care needs, had a diagnosis of diabetes mellitus, and received insulin injections daily. Observations in the third short hall medication cart on August 22, 2024, at 10:05 a.m. revealed that there was an glargine insulin pen (a medication used to treat diabetes mellitus) for Resident 19 that was opened and undated and was in use. Interview with Licensed Practical Nurse 8 on August 22, 2024, at 10:19 a.m. confirmed that the insulin pen for Resident 19 was in use and should have been dated when opened, but was not. Interview with the Nursing Home Administrator on August 22, 2024, at 12:40 p.m. confirmed that the narcotic storage box containing Ativan was not permanently affixed inside the refrigerator and insulin pens, once opened, must have an opened date placed on them. 28 Pa. Code 211.9(a)(1) Pharmacy Services.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 41233 Based on review of policies, as well as observations and interviews with residents and staff, it was determined that hot foods were not served at proper and palatable temperatures. Findings include: The facility's policy regarding food temperatures, dated June 1, 2024, indicated that the temperatures of hot foods were to be served at 135 degrees Fahrenheit (F) or above. Observations of tray line for the lunch meal in the main kitchen on August 21, 2024, revealed that the Second Floor food cart left the kitchen at 12:28 p.m. and arrived on the Second Floor at 12:32 p.m. The last resident was served at 12:43 p.m. At 12:45 p.m. the temperature of the chicken breast was 124 degrees F. The chicken breast was lukewarm to taste and not appetizing. Interview with Dietary Director on August 21, 2024, at 1:11 p.m. confirmed that the temperatures of hot foods should have been at 135 degrees F when served to residents. 28 Pa. Code 211.6(b) Dietary 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 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. 42079 Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that staff provided assistive devices to eat in accordance with the resident's care plan for two of 45 residents reviewed (Residents 12, 28). Findings include: The facility's policy regarding adaptive equipment, dated July 1, 2024, indicated that adaptive equipment to meet residents' needs would be provided per order. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 12, dated June 19, 2024, indicated that the resident was cognitively intact and required set-up assistance with eating. A speech therapy note, dated June 20, 2024, at 9:54 a.m. indicated that Resident 12 was to use a two-handled cup with all liquids. A nursing note for Resident 12, dated June 20, 2024, at 2:12 p.m., indicated that the resident was on a straw restriction. Observations of Resident 12 during the lunch meal on August 22, 2024, at 1:09 p.m. revealed that the resident was in the dining area on the third floor and had a can of soda with a straw and a carton of milk with a straw. Interview with Licensed Practical Nurse 10 on August 22, 2024, at 1:15 p.m. confirmed that Resident 12 did not have a two-handled cup for all liquids with her meal, which was not in accordance with the meal ticket. Interview with the Assistant Director of Nursing on August 22, 2024, at 1:39 p.m. confirmed that if Resident 12's meal ticket indicated that the resident was to have had two-handled cup with all liquids, then it should have been on her tray. A quarterly MDS assessment for Resident 28, dated August 9, 2024, revealed that the resident was understood, could understand, was cognitively intact, and required set up and clean up for eating. A care plan for Resident 28, revised on August 17, 2023, revealed that the resident was at risk for a nutritional problem. Interventions included having adaptive equipment for feeding, which included weighted built-up utensils. Current physician's orders for Resident 28 included an order for the resident to be provided black, weighted built-up utensils on all trays for all meals. Observations of Resident 28 during the lunch meal on August 22, 2024, at 12:50 p.m. revealed that the resident was in his room eating lunch with regular flatware. Resident 28 stated that he finds it very difficult to eat without his weighted black silverware. Interview with Nurse Aide 5 on August 22, 2024, at 12:56 p.m. confirmed that Resident 28 did not have built-up silverware with his meal, which was not in accordance with the meal ticket. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing on August 21, 2024, at 12:04 p.m. confirmed that Resident 28 should have been provided weighted silverware for his lunch meal as ordered. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41233 Based on review of policies, as well as observations and staff interviews, it was determined that the facility failed to ensure that food was stored and served in accordance with professional standards for food service safety. The facility failed to ensure that the kitchen and its equipment was clean; that food stored in the kitchen and pantries was labeled, dated and secured; that an ice cream freezer had a thermometer; that food was thawing properly; and that staff should wear hairnets that covered all of their hair. Findings include: The facility's policy regarding storage of perishable food and food safety, dated July 1, 2024, revealed that staff are to cover, label, and date unused portions and opened packages, thawing meat should be placed below other food items and never on the counter to thaw, and freezers will be equipped with an internal thermometer. The facility's policy regarding proper hygiene, dated July 1, 2024, revealed that sanitary practices were to be used during food preparation in the kitchen, and hair restraints were to be worn in a manner to cover all hair. Observations in the kitchen on August 19, 2024, between 9:05 a.m. and 9:13 a.m. revealed a microwave with a white, creamy substance that covered approximately half of the glass plate inside; water was pooled on the floor under the coffee machine; a meat slicer and large mixer with pieces of dried food remnants on the blade; a white, powdery substance that was stuck on the bowl and parts of the mixer; and the ice cream freezer that had no thermometer inside. Observations of the kitchen floor revealed that there were cups, lids, straws and general debris under the coffee counter, sink and throughout the kitchen. Observations on the top shelf of the cooks prep area revealed one bag of powdered chicken gravy mix and a 16-ounce bag of marshmallows that were opened and undated and exposed to air. Observations in the walk-in cooler on August 19, 2024, between 9:13 a.m. and 9:28 a.m. revealed 12 blueberry muffins, eight ham slices, five pounds of yellow cheese, and four pounds of shredded cheddar cheese that were opened and exposed to air and undated. There was a whip cream pipet that was opened and secured but had no opened date on the plastic wrap, and a pan of plastic covered watermelon chunks measuring approximately fifteen inches by twenty inches that was being stored under a shelf that contained a thawing 10-pound ham, two pounds each of ham and turkey slices, and 18 slices of bacon. Observations in the walk-in freezer on August 19, 2024, at 9:34 a.m. revealed two pie crusts and 27 pieces of pork mic-rib sandwich meat that was opened and exposed to air and undated. Observations in the second floor pantry freezer on August 20, 2024, at 11:14 a.m. revealed two boxes of vanilla ice cream bars, one box of coconut ice cream bars, and a 14-ounce container of ice cream that were opened, undated and unlabeled. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observations in the kitchen during tray line (plating of food for the next meal) on August 21, 2024, between 11:49 a.m. and 12:02 p.m. revealed that Dietary [NAME] 12, who was plating food, wore a hairnet with approximately two inches of hair tendrils down her neck and on the sides of her head exposed. Dietary Aide 11, who was pulling pork apart, wore a hairnet with approximately one inch of hair on her forehead and approximately three to four inches of hair on her neck exposed. Food Service Worker 12, who was scooping cottage cheese and fruit into bowls, wore a hairnet with approximately two to four inches of hair down the back of her head and one inch of hair tendrils on each side that was exposed and touching her collar. Observations in the kitchen on August 21, 2024, on 12:17 p.m. revealed a puddle of water under the ice machine that extended out onto the floor of the kitchen and a 10-pound ham thawing on the prep area counter. Interview with the Dietary Manager on August 22, 2024, at 11:20 a.m. confirmed that the above-mentioned kitchen and pantry concerns should not have occurred and that staff were to have their hair completely covered. 28 Pa. Code 211.6(f) Dietary Services.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 48941 Based on review of the facility's plans of correction and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to correct quality deficiencies and ensure that plans to improve the delivery of care and services effectively addressed recurring deficiencies. Findings include: The facility's deficiencies and plans of corrections for State Survey and Certification (Department of Health) survey ending September 8, 2023, revealed that the facility developed plans of correction that included quality assurance systems to ensure that the facility maintained compliance with cited nursing home regulations. The results of the current survey, ending August 22, 2024, identified repeated deficiencies related to failure to correct deficient practices related to accommodation of resident needs, accuracy of Minimum Data Set (MDS) assessments, professional standards of practice, quality care, safe environment free from accident hazards, nutrition and hydration maintenance, accounting of controlled medications, storage and labeling of medications, assistive devices to maintain eating and hydration needs, food preparation and storage, and infection control. The facility's plan of correction for a deficiency regarding a failure to accommodate the residents' needs, cited during the survey ending September 8, 2023, revealed that audits would be conducted, and the results of the audits would be brought before the QAPI committee for further monitoring. The results of the current survey, cited under F558, revealed that the QAPI committee was ineffective in correcting deficient practices related to accommodation of resident needs. The facility's plan of correction for a deficiency regarding the accuracy of MDS assessments, cited during the survey ending September 8, 2023, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F641, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding accuracy of MDS assessments. The facility's plan of correction for a deficiency regarding professional standards, cited during the survey ending September 8, 2023, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F658, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding professional standards. The facility's plan of correction for a deficiency regarding quality of care, cited during the survey ending September 8, 2023, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F684, revealed that the facility's QAPI committee was ineffective in maintaining compliance with the regulation regarding quality of care. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's plans of correction for deficiencies regarding a safe environment that is free of accident hazards, cited during the survey ending September 8, 2023, revealed that the facility developed plans of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F689, revealed that the facility's QAPI committee failed to maintain compliance with the regulation regarding a safe environment that is free of accident hazards. The facility's plan of correction for a deficiency regarding nutrition and hydration maintenance, cited during the survey ending on September 8, 2023, revealed that audits would be conducted, and the results of the audits would be brought before the QAPI committee for further monitoring. The results of the current survey, cited under F692, revealed that the QAPI committee was ineffective in maintaining compliance with the regulation regarding nutrition and hydration maintenance. The facility's plan of correction for a deficiency regarding complete and accurate accounting of controlled medications, cited during the survey ending September 8, 2023, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F755, revealed that the facility's QAPI committee failed to maintain compliance with the regulation regarding complete and accurate accounting of controlled medications. The facility's plans of correction for deficiencies regarding storage and labeling of medications, cited during the survey ending September 8, 2023, revealed that the facility developed plans of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F761, revealed that the facility's QAPI committee failed to maintain compliance with the regulation regarding storage and labeling of medications. The facility's plan of correction for a deficiency regarding assistive devices to maintain eating and hydration needs, cited during the survey ending on September 8, 2023, revealed that audits would be conducted, and the results of the audits would be brought before the QAPI committee for further monitoring. The results of the current survey, cited under F810, revealed that the QAPI committee was ineffective in maintaining compliance with the regulation regarding assistive devices to maintain eating and hydration needs. The facility's plan of correction for a deficiency regarding proper food preparation and storage, cited during the survey ending September 8, 2023, revealed that proper food preparation and storage would be monitored by QAPI. The results of the current survey, cited under F812, revealed that the QAPI committee was ineffective in maintaining compliance with proper food preparation and storage. The facility's plans of correction for deficiencies regarding infection control, cited during the surveys ending September 8, 2023, revealed that the facility developed plans of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F880, revealed that the facility's QAPI committee failed to maintain compliance with the regulation regarding infection control. Refer to F558, F641, F658, F684, F689, F692, F755, F761, F810, F812, F880. 28 Pa. Code 201.14(a) Responsibility of Licensee. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 201.18(e)(1) Management.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 48941 Based on review of attendance records for the facility's Quality Assurance Committee, as well as staff interviews, it was determined that the facility failed to ensure that Quality Assurance meetings were held at least quarterly. Findings include: Review of the attendance records for the facility's Quality Assurance Committee meetings revealed that there were no records of a meeting held during the facility's second quarter of 2024 (April, May and June of 2024). Interview with the Nursing Home Administrator on August 22, 2024, at 3:09 p.m. confirmed that there were no records of any Quality Assurance meetings held during the second quarter in 2024. She stated that they were to have a meeting in July 2024 but it was pushed back. She indicated that it had still not been scheduled as of this date. 28 Pa. Code 201.18(e)(1)(2)(3) Management.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 42079 Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment to prevent the transmission of infections. Findings include: The facility's policy for linen management, dated July 1, 2024, revealed that soiled linens will be bagged at the point of use and placed in a soiled linen bin in the designated area. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 11, dated August 6, 2024, revealed that the resident was sometimes understood, could sometimes understand others, was cognitively impaired, and was dependent on staff for all care needs. Observations of Resident 11's room on August 19, 2024, at 12:00 p.m. and 12:25 p.m. revealed a sign for contact precautions and to see the nurse for instructions. Interview with Licensed Practical Nurse 8 on August 19, 2024, at 12:10 p.m. regarding the sign revealed that Resident 11 was COVID-19 positive and was on droplet precautions (requiring a gown, gloves, N-95 mask and eye protection), not contact precautions. A tracking log for 2024 indicated that Resident 11 tested positive for COVID-19 (acute disease in humans caused by a coronavirus) on August 12, 2024. There was personal protective equipment (PPE) available on the door. There was no soiled bin for the used/contaminated PPE to be placed in. There was only one laundry basket that staff were moving from COVID-19 positive rooms as needed. The laundry basket had a lid, but there was no bag in it, which allowed the contaminated PPE to be exposed through the sides. Staff wheeled the laundry basket over to Resident 11's room so the used gown, gloves, and eye protection could be removed. Interview with the Director of Nursing on August 21, 2024, at 4:12 p.m. confirmed that the correct transmission based precaution signs should have been posted, and that there should have been appropriate receptacles to remove soiled/used PPE when exiting the room of someone who is on droplet isolation. Observations on August 19, 2024, at 12:38 p.m. revealed that Nurse Aide 13 carried dirty linens from one end of the hall to the middle of the hall and placed them in a linen bin. Interview with Nurse Aide 13 on August 19, 2024, at 12:40 p.m. confirmed that she was carrying the linens from a droplet isolation room (prevent the spread of germs when they are able to be spread through the air) to a linen cart in the middle of the hallway and should have had a dirty linen bin available inside the droplet isolation room. Interview with Nursing Home Administrator on August 21, 2024, at 10:40 a.m. confirmed that the isolation rooms should have had their own dirty linen bin in each room, and that Nurse Aide 13 should not have been carrying unbagged, dirty linens from a droplet isolation room through the hall. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 48941 Based on review of facility policies, infection control documentation, and staff interviews, it was determined that the facility failed to implement an antibiotic stewardship program that contained a system of reports and forms, and collaboration with an interdisciplinary team approach to monitor, track and trend antibiotic use and resistance for seven consecutive months (January 2024 through July 2024). Findings include: A facility policy regarding Antimicrobial Stewardship Program, dated July 1, 2024, indicated that the antimicrobial stewardship will focus on improving antibiotic/antimicrobial use by avoiding unnecessary or inappropriate antibiotics. The process will be overseen and managed by the Infection Preventionist (IP) who works collaboratively with the medical director, consulting pharmacist, nursing and administrative leadership to also implement the Antimicrobial Stewardship Program (ASP). As a component of the monthly Infection and Prevention and Control Committee (IPCC) meeting, the facility's use of antibiotics will be reviewed to include monitoring and tracking of antibiotic prescribing, use, and resistance. Review of the facility infection control binder containing the documentation to support that the facility followed their policies and procedures related to their Antibiotic/Antimicrobial Stewardship Program revealed that there was no documented evidence to support that the facility implemented their Antibiotic/Antimicrobial Stewardship Program (ASP) over the last seven consecutive months (January 2024 through July 2024). The last available information the facility had related to antibiotic monitoring, tracking and trending was from 2023. Interview with the Infection Preventionist (IP) on August 20, 2024, at 4:12 p.m. revealed that as of April 2024, when she assumed the position as the IP, the facility has not monitored antibiotic use as per the facility's antibiotic/antimicrobial stewardship program. She indicated that she was not trained after receiving her required IP education from the Center of Disease Control (CDC) in March 2024 and assuming the role as IP. She indicated that she had no documented evidence that antibiotic monitoring, tracking and trending occurred since January 2024. Interview with the Nursing Home Administrator on August 20, 2024, at 4:15 p.m. confirmed that the facility was not following their antibiotic/antimicrobial stewardship program and had not been monitoring, tracking and trending antibiotic use since the IP assumed the role in March 2024. The Nursing Home Administrator also confirmed they had no documentation to support that antibiotic use was monitored, tracked and trended since January 2024. She revealed that the current IP's last day in that position would be August 22, 2024, and that they had hired a new IP that would be starting soon. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1) Management.

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	08/22/2024

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 42079 Based on review of facility policy and clinical records, as well as observations and resident and staff interviews, it was determined that the facility failed to ensure that the call bell system was adequately equipped to allow residents to call for staff assistance, by failing to ensure that the call bell system was working for one of 45 resident reviewed (Resident 34). Findings include: The facility's policy regarding resident communication system and call lights, dated April 30, 2024, revealed that it was the policy of the facility to provide residents with a means of communicating with staff. A call system is installed in each resident room and toilet/bath area. The facility will respond to resident needs and requests. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 34, dated August 6, 2024, revealed that the resident was understood, could understand others, was cognitively impaired, and required staff assistance for all care needs. Observations on August 19, 2024, at 1:00 a.m. revealed that Resident 34 was sitting in bed with her call bell in her hand. Resident 34 pressed her call bell but it did not function and no light came on to indicate the call bell was activated. Interview with Nurse Aide 5 at 1:10 p.m. revealed that she did not receive a notification on her beeper, she was unsure why the call bell was not functioning, and would notify maintenance. Interview with the Maintenance Director on August 21, 2024, at 1:10 p.m. revealed that the call bell system was battery operated and the batteries need to be replaced frequently. Interview with the Nursing Home Administrator on August 22, 2024, at 3:10 p.m. revealed that the call bell should be functioning, and if not the resident should have a cow bell. 28 Pa. Code 207.2(a) Administrator's Responsibility. 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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 41233 Based on observations, a review of clinical records, as well as staff interviews, it was determined that the facility failed to maintain an effective pest control program. Findings include: The facility's policy on pest control, dated July 1, 2024, indicated that the facility will maintain a pest control program and that treatment will be rendered as required to control insects. Observations of the cooks prep area/sink in the kitchen on August 19, 2024, at 9:10 a.m. revealed approximately six flies and several gnats in the sink around the food prep area. There were also several gnats in the general area of the kitchen. Interview with the Dietary Manager on August 19, 2024, at 9:20 a.m. revealed that she did realize that the flies and gnats were there and indicated that maintenance was aware and had a pest control company in several times; however, the problem remains. Interview with the Maintenance Director on August 20, 2024, at 3:05 p.m. revealed that the pest control company was coming every other month, and they were last there June 20, 2024. He indicated that the pest control company generally comes between the 15th and 22nd of the month, and that they were due to come to the facility. Once he was made aware of the concern regarding the kitchen, he requested the company come to the facility that day, which was August 19, 2024. Floor and sink drains in the kitchen and washroom were treated. Recommendations by the pest control company included a thorough cleaning of the kitchen and dish area, eliminating all food debris, proper ventilation, and fly lights. The Maintenance Director indicated that the pest control company will now come monthly. Interview with the Nursing Home Administrator on August 21, 2024, at 2:26 p.m. confirmed that flies and gnats should not be in the kitchen. 28 Pa. Code 207.2(a) Administrator's Responsibility. 28 Pa. Code 201.18(e)(2)(3) Management.