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	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midtown Oaks Health & Rehab Center	1020 Green Avenue Altoona, PA 16601

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. Based on review of policies, observations and staff interviews, it was determined that the facility failed to ensure that food was stored, prepared, distributed and served in accordance with professional standards for food service safety in the kitchen, in one of two pantries (second floor) and one of two refrigerators (third floor pantry) observed.Findings include: The facility policy regarding food storage, dated April 29, 2025, revealed that any food that has been opened must be labeled, dated and secured in such a way that the food item is not open to air, and that the facility would ensure a clean and sanitary environment. The facility's policy regarding food production and safety, dated April 29, 2025, revealed that the purpose of the policy was to ensure food would be cooked and/or held at appropriate temperatures to maintain safety, and that temperatures would be taken prior to meal service. Observations in the main kitchen's walk in freezer on September 8, 2025, at 9:30 a.m. revealed that there were 25 egg omelets, 15 sausage patties, five chicken cutlets, six pork chops and approximately one third of a bag of cut frozen carrots that were not dated with an opened date and were all open to the air. Observations on the back wall of the main walk in freezer on September 8, 2025, at 9:35 a.m. revealed that there was an approximate three foot by one and one half foot build up of ice. This ice extended from the pipe below the ceiling into and through the lid of a cardboard box that contained bags of frozen perogies.Observations in the second floor panty on September 8, 2025, at 3:35 p.m. revealed that there were, 3 boxes of frozen waffles that were undated and open to the air, and a box containing one and one half pieces of pizza that was not dated or labeled with a resident name. Observations in the third floor pantry refrigerator on September 8, 2025, at 3:40 p.m. revealed a moderate amount of an orange colored dried on sticky substance on the lower bottom right storage drawer.Observations in the kitchen on September 9, 2025, at 9:32 a.m. and September 10, 2025, at 8:40 a.m. respectively, revealed that there were four washed and ready to use insulated serving bowls that had a moderate amount of a dried white food substance on them, six plastic measuring cups, and one large plastic pitcher, all of which were in circulation for kitchen use, that had a moderate to large amount of a removable substance inside them.Observations in the kitchen of the bottom shelf of the stainless steel prep table on September 10, 2025, at 11:31 a.m. revealed that there was one five pound bag of dried noodles that was labeled and dated, but was open to the air.Observations in the kitchen on September 10, 2025, at 12:10 p.m. revealed that [NAME] 2 was plating food for the lunch meal. The menu was a cold meal that included a turkey sandwich and macaroni salad. A hot substitute choice of hamburgers, mashed potatoes and gravy was available and was observed to be plated for a resident. Observations of the lunch food temperature log revealed that the temperatures of the hot food items were not obtained to ensure that food was served at the proper temperature. Interview with the Regional Dietician 3 on September 10, 2025, at 12:10 p.m. confirmed that the food temperature log did not indicate that the hot foods were temped (temperature was taken) prior to plating. She further indicated that all food items whether hot or cold are required to be monitored for the proper temperature and documented as such. Interview with the Nursing Home Administrator on September 11, 2025, at 10:01 a.m. confirmed that all food items in the kitchen and pantry should be labeled, dated and not open to the air, that dinnerware/serving ware and facility (continued on next page)

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

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

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	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midtown Oaks Health & Rehab Center	1020 Green Avenue Altoona, PA 16601

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	freezers and refrigerators should be sanitary and in good working order, and that all food should be temped prior to being served to residents, and they were not.28 Pa. Code 211.6(f) Dietary services.

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	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midtown Oaks Health & Rehab Center	1020 Green Avenue Altoona, PA 16601

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. Based on a review of the Resident Assessment Instrument User's Manual and clinical records, as well as staff interviews, it was determined that the facility failed to complete accurate Minimum Data Set assessments for four of 50 residents reviewed (Residents 3, 8, 45, 82). Findings include:The Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (required assessments of a resident's abilities and care needs), dated October 2024, indicated that Section O0110C1, oxygen therapy, was to be coded if oxygen was administered at any time within the last 14 days.Physician's orders for Resident 3, dated June 24, 2024, included orders for the resident to receive two liters/minute of oxygen as needed every shift to keep her oxygen saturation (percentage of oxygen in the blood) greater than 90%.Review of the Medication Administration Records for Resident 3, dated May and June 2025, revealed that the resident received oxygen within the last 14 days of the assessment period.A quarterly MDS assessment for Resident 3, dated June 24, 2024, revealed that Section O0110C1 was not coded indicating that the resident did not receive oxygen therapy within the last 14 days of the assessment period. Interview with the Registered Nurse Assessment Coordinator (RNAC- responsible for the completion of the MDS), on September 11, 2025, at 1:25 p.m. confirmed that Resident 3's quarterly MDS assessment was coded incorrectly and should have been coded to indicate that the resident received oxygen therapy within the last 14 days of the assessment period.The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides guidance and instructions for the completion of Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2024, indicated that the intent of Section N0415E Anticoagulant (blood thinner) was to be coded if the resident took the medication during the seven-day lookback period.Physician's order for Resident 45 dated August 20, 2025, included an order for the resident to receive 40 milligram/milliliter)(mg/ml)of Enoxaparin (anticoagulant) subcutaneous (injection in the skin) daily.An admission MDS assessment for Resident 45 dated August 27, 2025, revealed that Section N0415E indicated that the resident did not receive an anticoagulant in the last seven days.A review of Resident 45's August 2025 Medication Administration Record revealed that the resident did receive 50 mg/ml of Enoxaparin daily during the seven-day look-back period.Interview with the Registered Nurse Assessment Coordinator on September 11, 2025 at 9:28 a.m. confirmed that Resident 45's MDS assessment was coded inaccurately. The RAI User's Manual, dated October 2024, indicated that the intent of Section C was to assess the mental status of the resident by conducting a brief interview for mental status. A comprehensive MDS assessment for Resident 8, dated July 29, 2025, revealed that Section C0100 indicated that the resident was to be interviewed for mental status. However, Sections C0200 - C0500 were coded not assessed.The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides guidance and instructions for the completion of Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2024, indicated that the intent of Section N was to record the number of days, during the seven days of the assessment period, that any type of injection, insulin, and/or select medications were received by the resident. Section N0415H was to be coded yes if the resident received an opioid medication.Physician's orders for Resident 82, dated April 15, 2025, include oxycodone (an opioid medication) daily for severe headaches. The resident's Medication Administration Record (MAR) for June 2025 revealed that the resident received Oxycodone daily during the assessment period.A quarterly MDS assessment for Resident 82, dated June 3, 2025, revealed that Section N0415H indicated that the resident did not receive an opioid medication during the assessment period. An interview with the Registered Nurse Assessment Coordinator (Registered Nurse responsible for accurate reporting information) on September 11, 2025 at 1:28 p.m. confirmed that Residents 8 and 82's MDS assessments were not coded correctly.28 Pa. Code 211.5(f) Medical records28 Pa. Code 211.12(d)(1)(5) Nursing services

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	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midtown Oaks Health & Rehab Center	1020 Green Avenue Altoona, PA 16601

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on review of the facility's plans of correction for previous surveys, and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to maintain compliance with nursing home regulations 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 correction for a State Survey and Certification (Department of Health) survey ending August 22, 2024, December 23, 2024, and April 22, 2025 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 September 11, 2025, identified repeated deficiencies related to accuracy of Minimum Data Set (MDS) assessments (mandated assessment of a resident's abilities and care needs), care plan timing and revision, preventing issues with the accountability of controlled medications (drugs with the potential to be abused), monthly pharmacy reviews, proper storage of medications, and food procurement-storing/preparing/serving food under sanitary conditions.The facility's plan of correction for a deficiency regarding a failure to ensure that MDS assessments were accurate upon submission, cited during the survey ending April 3, 2024, 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 F641, revealed that the facility's QAPI committee was ineffective in correcting deficient practices related to accurate MDS assessments. The facility's plan of correction for a deficiency regarding care plan timing and revision, cited during the survey ending August 22, 2024 and December 23, 2024, 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 F657, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding care plan timing and revision.The facility's plans of correction for deficiencies regarding the failure to account for controlled medications, cited during the survey ending August 22, 2024, revealed that the facility would complete audits and the results would be reviewed as part of quality assurance. The results of the current survey, cited under F755, revealed that the facility's QAPI committee was ineffective in correcting deficient practices related to the accountability of controlled medications. The facility's plan of correction for a deficiency regarding monthly pharmacy reviews, cited during the survey ending August 22, 2024, 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 F756, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding monthly pharmacy reviews.The facility's plan of correction for a deficiency regarding label/store drugs and biologicals, cited during the survey ending August 22, 2024, 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 F761, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding label/store drugs and biologicals. The facility's plan of correction for a deficiency regarding labeling and storing food under sanitary conditions, cited during the survey ending August 22, 2024 and April 22, 2025, 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 F812, revealed that the QAPI committee was ineffective in correcting deficient practices related to food procurement-storing/preparing/serving food under sanitary conditions. Refer to F641, F657, F755, F756, F761, F81228 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(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	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midtown Oaks Health & Rehab Center	1020 Green Avenue Altoona, PA 16601

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the Resident Assessment Instrument User's Manual and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that comprehensive admission Minimum Data Set assessments were completed in the required time frame for four of 50 residents reviewed (Residents 35, 45, 89, 117). Findings include:The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2023, indicated that an admission MDS assessment was to be completed no later than 14 days (admission date + 13 calendar days) following admission.A comprehensive admission MDS assessment for Resident 35, dated July 8, 2025, revealed that the resident was admitted to the facility on [DATE], and the resident's admission MDS assessment was dated as completed on July 15, 2025, which was 14 days after admission.A comprehensive admission MDS assessment for Resident 45, dated August 27, 2025, revealed that the resident was admitted to the facility on [DATE], and the resident's admission MDS assessment was dated as completed on September 3, 2025, which was 14 days after admission.A comprehensive admission MDS assessment for Resident 89, dated August 25, 2025, revealed that the resident was admitted to the facility on [DATE], and the resident's admission MDS assessment was dated as completed on September 3, 2025, which was 14 days after admission.A comprehensive admission MDS assessment for Resident 117, dated May 21, 2025, revealed that the resident was admitted to the facility on [DATE], and the resident's admission MDS assessment was dated as completed on June 2, 2025, which was 16 days after admission.An interview with Nursing Home Administrator on September 11, 2025, at 12:08 p.m. confirmed that the admission MDS assessments listed above were not completed within the required time frames.28 Pa. Code 211.5(f) Clinical Records.

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	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midtown Oaks Health & Rehab Center	1020 Green Avenue Altoona, PA 16601

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a resident's care plan was updated/revised to reflect the resident's specific care needs for two of 50 residents reviewed (Residents 6 and 7).Findings include: The facility's policy regarding care plans, dated April 29, 2025, indicated that the facility will develop a comprehensive person-centered care plan for each resident that includes measurable goals, and timetables to meet the resident's medical, nursing, mental and psychosocial needs identified in the comprehensive assessment. The care plan is reviewed on an on-going basis and revised as indicated by the resident's needs, wishes or a change in condition. At a minimum, this will occur with each comprehensive, quarterly, assessment in accordance with Resident Assessment Instrument (RAI) requirements. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 6, dated June 10, 2025, revealed that the resident was cognitively intact, required assistance with care needs, had five venous ulcers (ulcers caused by problems with blood flow in the leg veins), had a diabetic foot ulcer (a wound to the foot due to a complication of diabetes), had an unstageable pressure ulcer (full-thickness pressure injuries in which the base is obscured by slough and/or eschar) not present on admission, and had diagnoses that included chronic venous hypertension (a condition where the veins in the legs cannot effectively return blood to the heart, resulting in increased pressure in the veins) and diabetes. A care plan for the resident, dated September 9, 2025, indicated that the resident had a potential for altered skin integrity and/or pressure injuries and included an intervention for a pressure redistribution mattress. A physician's order for Resident 6, dated December 18, 2024, included an order for the resident to have a 42-inch concord mattress (an alternating air pressure mattress used to relieve pressure and improve blood flow) with a bolster overlay (creates a raised edge/defined perimeter for fall prevention) and a gap filler (fills in gaps between the mattress and the bed frame). There was no documented evidence in the resident clinical record that the care plan was revised to include the intervention for the concord mattress with the bolster overlay and gap filler. Interview with the Director of Nursing on September 11, 2025, at 9:38 a.m. confirmed that Resident 6's care plan was not revised to reflect that the concord mattress with bolster overlay and gap filler was added to the resident's bed on December 18, 2024. A quarterly MDS assessment for Resident 7, dated June 25, 2025, revealed that the resident was cognitively intact, required supervision with care needs and ambulation, was independent with wheelchair mobility, was frequently incontinent of bowel and bladder, did not receive a diuretic medication (a medication used to treat fluid build-up in the body), and had a diagnosis of hypertension (high blood pressure). A care plan for the resident, dated July 3, 2023, included an intervention for the resident to monitor for adverse reaction to diuretic therapy and to hold medications as ordered for systolic blood pressure (SBP-the top number) less than 100 millimeters of mercury (mmHg) and/or a heart rate less than 60 beats per minute (bpm). Review of Resident 7's clinical record, including review of the resident's Medication Administration Record (MAR) and physician's orders, revealed no documented evidence that the resident was receiving a diuretic medication and no documented evidence that an order was in place to hold a medication for a SBP less than 100 mmHg and/or a heart rate less than 60 bpm. Interview with the Director of Nursing on September 11, 2025, at 11:50 a.m. confirmed that Resident 7's care plan was not revised to reflect that she was no longer on a diuretic medication and that parameters for the holding medications for a heart rate of less than 60 bpm were discontinued. 28 Pa. Code 211.12(d)(5) Nursing Services.

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	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midtown Oaks Health & Rehab Center	1020 Green Avenue Altoona, PA 16601

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to maintain a complete and accurate accounting of controlled medications (medications with the potential to be abused) for two of 50 residents reviewed (Residents 46, 53). Findings include:The facility's policy regarding medication administration, dated April 29, 2025, indicated that staff are to document the administration of controlled substances in accordance with applicable law.A quarterly Minimum Data Set (MDS) Assessment (a mandated assessment of a resident's abilities and care needs) for Resident 46 dated August 4, 2025 revealed that the resident is cognitively impaired, required assistance from staff for daily care needs and had medical diagnosis that include dementia and heart failure.Physician's orders for Resident 46, dated May 13, 2025, included an order for the resident to receive 10 milligrams (mg) of Oxycodone (a controlled narcotic pain medication) orally every 4 hours for pain.A review of Resident 46's-controlled drug record (used to keep count of narcotic medication) for June, July and August 2025 revealed that staff signed out one 10 mg Oxycodone on June 13 2025 at 8:17 a.m.; July 16, 2025 at 8:00 a.m.; July 24, 2025 at 1:15 p.m.; July 31, 2025 at 12:30 p.m.; August 1, 2025 at 8:30 a.m.; August 1, 2025 at 2:00 p.m.; August 13, 2025 at 8:07 p.m.; August 18, 2025 at 9:09 p.m.; and August 27, 2025 at 8:15 a.m. However, review of the resident's MAR, dated June, July and August 2025, revealed no documented evidence that the 10 mg of Oxycodone was administered to the resident on those dates.Interview with the Director of Nursing on September 11, 2025, at 10:38 a.m. confirmed that there was no documented evidence that Resident 46 received the 10 mg of Oxycodone as ordered on the above referenced dates.A quarterly MDS assessment for Resident 53, dated July 10, 2025, revealed that the resident was cognitively intact, received routine pain medications, and received an opioid (a controlled narcotic pain medication).Physician's orders for Resident 53, dated April 19, 2025, included orders for the resident to receive 5 milliliters (ml) of oxycodone (a controlled narcotic pain medication) every six hours as needed for severe pain. Review of Resident 53's controlled drug accountability records for July, August, and September, 2025 revealed that one dose of Oxycodone was signed out for administration to the resident on July 10 at 9:45 p.m.; July 14 at 9:30 a.m.; July 27 at 9:30 a.m.; August 10 at 9:45 a.m.; August 12 at 9:22 p.m.; August 18 at 8:30 a.m.; August 23 at 9:00 a.m.; and September 1 at 8:30 a.m. There was no documented evidence that the signed-out doses of oxycodone were administered to the resident. Interview with the Director of Nursing on September 11, 2025, at 11:32 a.m. confirmed that there was no documented evidence that the signed-out doses of oxycodone were actually administered to Resident 53 on the dates and times mentioned. 28 Pa. Code 211.9(h) Pharmacy Services.28 Pa. Code 211.12(d)(1) Nursing Services.

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	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midtown Oaks Health & Rehab Center	1020 Green Avenue Altoona, PA 16601

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to respond to a pharmacy recommendation for one of 50 residents reviewed (Resident 7). Findings include: A facility policy related to medication regimen review, dated April 29, 2025, indicated that the consultant pharmacist will conduct medication regimen reviews (MRRs) and will make recommendations based on the information made available in the resident's health record. The consultant pharmacist will provide the resident's MRRs to the facility identified personnel who will ensure that the attending physician, medical director, and other necessary facility staff receive the recommendations. The facility should maintain readily available copies of the consultant pharmacist's reports on file in the facility, and as a part of the resident's permanent health record. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 7, dated June 25, 2025, revealed that the resident was cognitively intact, required supervision with care needs and ambulation, was independent with wheelchair mobility, received insulin, antianxiety medications, antidepressant medications, opioid medications and had a diagnosis of hypertension (high blood pressure) and Multiple Sclerosis (MS-chronic disease that affects nerves in the brain and spinal cord). A pharmacy medication regimen note for Resident 7, dated April 7, 2025, at 11:25 a.m. indicated that irregularities/recommendations were noted and to see the report for any noted irregularities and/or recommendations. There was no documented evidence in the resident's clinical record of the recommendations made on April 7, 2025, and that the recommendations from the pharmacist were addressed by the physician. An interview with the Director of Nursing on September 10, 2025, at 3:58 p.m. indicated that she was unable to find the pharmacy recommendations for Resident 7, dated April 7, 2025, and confirmed that the recommendation was not addressed by the physician. 28 Pa. Code 211.10(c) Resident care policies. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services.

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	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midtown Oaks Health & Rehab Center	1020 Green Avenue Altoona, PA 16601

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. Based on observations, and staff interviews, it was determined that the facility failed to ensure that medications were properly stored for one of 50 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 August 21, 2025, indicated that the resident was cognitively intact, required assistance from staff for daily care needs, received a antipsychotic medication, antidepressant medication, anticoagulant medication, diuretic medication and a hypoglycemic medication. Resident 56 had diagnoses that included diabetes, depression, high blood pressure, and deep vein thrombosis (blood clot). Observation of Resident 56 on September 8, 2025, at 9:13 a.m. revealed the resident was lying in bed and an unsupervised medicine cup containing 10 unlabeled clean and dry pills was sitting on her overbed table. An unlabeled medication was sitting on her bedside table, cut in half. Interview with Resident 56 at that time revealed that they were her morning medications that the nurse left for her to take. Interview with Licensed Practical Nurse 1 on September 8, 2025, at 9:29 a.m. indicated that Resident 56 is permitted to take her medications on her own and stated that she has to take her medications with food. There was no documented evidence in the resident's clinical record that indicated she was assessed for self-administration of medications. Interview with Licensed Practical Nurse 1 on September 8, 2025, at 11:45 a.m. indicated that she is new, and the person that trained her told her that Resident 56 took her own medications. She did confirm that this was not correct and indicated that if the resident were permitted to take her own medications, it would be noted in the physician's orders. An interview with the Director of Nursing on September 8, 2025, at 1:12 p.m. confirmed that Resident 56's medications should not have been left unsupervised and unlabeled at the bedside. 28 Pa. Code 211.9(a)(1) Pharmacy Services. 28 Pa. Code 211.12(d)(1) Nursing Services.