

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395985	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 06/25/2025
--	---	---	--

NAME OF PROVIDER OR SUPPLIER: MIDTOWN OAKS HEALTH & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE: 1020 GREEN AVENUE ALTOONA, PA 16601
STATE LICENSE NUMBER: 065402	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT	F 0000		
F 0677 SS=D	Based on a complaint survey completed on June 25, 2025, it was determined that Midtown Oaks Health and Rehab Center was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0677		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395985	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 06/25/2025
NAME OF PROVIDER OR SUPPLIER: MIDTOWN OAKS HEALTH & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 1020 GREEN AVENUE ALTOONA, PA 16601		
STATE LICENSE NUMBER: 065402				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0677 SS=D	Continued from page 1 483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 0677	Residents # 4, 5, 6, and 7 have had no adverse effects from not being showered according to preference. Residents 4,5, 6, and 7 were showered according to preference as care planned. To identify residents who have the potential to be affected, the Director of nursing/ designee will complete an audit of shower preferences and ensure care plans are accurate. To prevent recurrence, the licensed nursing staff and nurse aides will be educated on the facility Resident bathing/showering/scheduling policy by the Director of nursing/ designee. To maintain and monitor compliance, audits of 6 residents to ensure showers are completed according to preference audits will be completed weekly x's 4 and monthly x's2.	Completion Date: 07/10/2025 Status: APPROVED Date: 07/09/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395985	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 06/25/2025
NAME OF PROVIDER OR SUPPLIER: MIDTOWN OAKS HEALTH & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 1020 GREEN AVENUE ALTOONA, PA 16601		
STATE LICENSE NUMBER: 065402				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0677 SS=D	Continued from page 2 Based on review of facility policies, clinical records, and shower schedules, as well as staff and resident interviews, it was determined that the facility failed to ensure that residents were provided with showers as scheduled for four of nine residents reviewed (Residents 4, 5, 6, 7). Findings include: The facility policy for bathing and showering, dated April 29, 2025, indicated that residents will be bathed or showered according to their preferences in order to maintain healthy hygiene and skin condition. Each resident will be asked about his/her bathing preferences upon admission (type of bath, preferred days and times). Each resident will be scheduled to receive bathing a minimum of two times per week. If the bath/shower cannot be given or the resident refuses, the nursing assistant will promptly report this to the charge nurse. The charge nurse will speak to the resident who refuses to ascertain why they are refusing and to determine	F 0677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395985	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 06/25/2025	
NAME OF PROVIDER OR SUPPLIER: MIDTOWN OAKS HEALTH & REHAB CENTER STATE LICENSE NUMBER: 065402		STREET ADDRESS, CITY, STATE, ZIP CODE: 1020 GREEN AVENUE ALTOONA, PA 16601		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0677 SS=D	<p>Continued from page 3</p> <p>if alternative arrangements that suit the resident can be made. If the resident continues to refuse, the charge nurse will document the resident's refusal in the medical record.</p> <p>An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) assessment for Resident 4, dated June 12, 2025, revealed that the resident was cognitively intact, required assistance with care needs including bathing and toileting hygiene, was frequently incontinent of bowel and bladder, and had a diagnosis of diabetes.</p> <p>An interview with Resident 4 on June 25, 2025, at 10:05 a.m. revealed that he has had one shower since he was admitted to the facility, and he had been at the facility for about two weeks. A review of Resident 4's clinical record revealed that the resident was admitted on June 9, 2025. A review of Resident 4's bathing detail report for June 2025 revealed that he had received one shower since he was admitted to the facility. There was no</p>	F 0677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395985	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 06/25/2025	
NAME OF PROVIDER OR SUPPLIER: MIDTOWN OAKS HEALTH & REHAB CENTER STATE LICENSE NUMBER: 065402		STREET ADDRESS, CITY, STATE, ZIP CODE: 1020 GREEN AVENUE ALTOONA, PA 16601		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0677 SS=D	Continued from page 4 documented evidence that the resident's bathing/shower preferences were obtained on admission and no documented evidence that the resident received a bath/shower a minimum of two times per week per facility policy. Interview with the Director of Nursing on June 25, 2025, at 3:50 p.m. indicated that shower preferences were obtained for Resident 4 on admission; however, the preferences were not documented in the resident's clinical record including the resident's care plan and shower schedule. She confirmed that there was no documented evidence that Resident 4 received showers per facility policy. An admission MDS assessment for Resident 5, dated May 18, 2025, revealed that the resident was cognitively intact, required assistance with care needs including bathing and toileting hygiene, was frequently incontinent of bowel and occasionally incontinent of bladder, and had a diagnosis including morbid obesity.	F 0677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395985	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 06/25/2025	
NAME OF PROVIDER OR SUPPLIER: MIDTOWN OAKS HEALTH & REHAB CENTER STATE LICENSE NUMBER: 065402		STREET ADDRESS, CITY, STATE, ZIP CODE: 1020 GREEN AVENUE ALTOONA, PA 16601		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0677 SS=D	<p>Continued from page 5</p> <p>A physician's order for Resident 5, dated May 12, 2025, included an order for the resident to receive a shower on Wednesday and Friday mornings. A care plan for Resident 5, dated May 14, 2025, included an intervention that the resident was to receive a shower in the mornings on Wednesdays and Fridays and to offer bed baths if he refused and document.</p> <p>A review of the bathing detail report for Resident 5 for May and June 2025 revealed that there was no documented evidence that the resident received his showers per physician's orders and preference, and there was no documented evidence that the resident refused his showers, requiring a bed bath be given.</p> <p>Interview with the Director of Nursing on June 25, 2025, at 3:50 p.m. confirmed that there was no documented evidence that Resident 5 received or refused showers from May to June 2025 as per the resident's orders/preferences and plan of care.</p> <p>A quarterly MDS assessment for Resident 6, dated</p>	F 0677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395985	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 06/25/2025
NAME OF PROVIDER OR SUPPLIER: MIDTOWN OAKS HEALTH & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 1020 GREEN AVENUE ALTOONA, PA 16601		
STATE LICENSE NUMBER: 065402				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0677 SS=D	Continued from page 6 May 6, 2025, revealed that the resident was cognitively impaired, required assistance with care needs including bathing and toileting hygiene, was occasionally incontinent of bowel and bladder, and had a diagnosis of diabetes. A physician's order for Resident 6, dated March 11, 2025, included an order for the resident to receive a shower every other day in the evening and to document in the progress notes any refusal, offer bed bath, notify medical director and power of attorney. A care plan for Resident 6, dated December 19, 2024, included an intervention that the resident prefers to shower every other day in the evenings. A review of the bathing detail report for Resident 6 from March 2025 through June 2025 revealed that there was no documented evidence that the resident received her shower's per physician's orders and preference, and there was no documented evidence that the resident refused her showers, requiring a bed bath be given.	F 0677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395985	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 06/25/2025
NAME OF PROVIDER OR SUPPLIER: MIDTOWN OAKS HEALTH & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 1020 GREEN AVENUE ALTOONA, PA 16601		
STATE LICENSE NUMBER: 065402				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0677 SS=D	Continued from page 7 Interview with the Director of Nursing on June 25, 2025, at 3:50 p.m. confirmed that there was no documented evidence that Resident 6 received and/or refused showers from March 2025 through June 2025 as per the resident's orders/preferences and plan of care. An annual MDS assessment for Resident 7, dated June 9, 2025, revealed that the resident was cognitively intact, required assistance with care needs including bathing and toileting hygiene, was occasionally incontinent of bowel and bladder, and had diagnoses including diabetes and peripheral vascular disease (a disease causing poor blood circulation to lower limbs). A physician's order for Resident 7, dated March 11, 2025, included an order for the resident to receive a shower on Mondays, Wednesdays, and Fridays in the a.m. and to document in the progress notes any refusal, offer bed bath, notify medical director and power of attorney. A care plan for Resident 7,	F 0677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395985	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 06/25/2025	
NAME OF PROVIDER OR SUPPLIER: MIDTOWN OAKS HEALTH & REHAB CENTER STATE LICENSE NUMBER: 065402		STREET ADDRESS, CITY, STATE, ZIP CODE: 1020 GREEN AVENUE ALTOONA, PA 16601		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0677 SS=D	<p>Continued from page 8</p> <p>dated August 6, 2024, included an intervention that the resident prefers to shower on Monday, Wednesday, and Friday on the first shift and may have a complete bed bath if she refuses a shower.</p> <p>A review of the bathing detail report for Resident 7 from March 2025 through June 2025 revealed that there was no documented evidence that the resident received her shower's per physician's orders and preference, and there was no documented evidence that the resident refused her showers, requiring a bed bath be given.</p> <p>Interview with the Director of Nursing on June 25, 2025, at 3:50 p.m. confirmed that there was no documented evidence that Resident 7 received and/or refused showers from March 2025 through June 2025 as per the resident's orders/preferences and plan of care.</p> <p>28 Pa. Code 211.12(d)(5) Nursing Services.</p>	F 0677		



Certified End Page

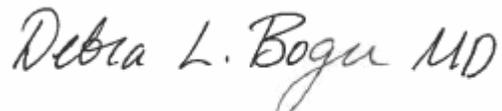
MIDTOWN OAKS HEALTH & REHAB CENTER

STATE LICENSE NUMBER: 065402

SURVEY EXIT DATE: 06/25/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY