STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255171	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDDLETON OAKS HEALTH AND REHABILITATION	**627 MIDDLETON ROAD , WINONA, Mississippi, 38967**

(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 DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The State Agency (SA) conducted a Complaint Investigation (CI MS# 2725825) at the facility on 3/31/26. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid Services. The SA identified non-compliance and cited F656 and F688 related to failure to implement care plan and failure to provide services to prevent a decline in range of motion. The census at the time of the survey was 97 with a bed capacity of 117 beds.	F0000		
F0656 SS = G	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical	F0656		

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0656 SS = G	Continued from page 1 record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, observation and facility policy review the facility failed to implement the comprehensive person-centered care plan related to contracture management and splinting to prevent decline in Range of Motion (ROM) for one (1) of three (3) resident reviewed. Resident #1. Findings Included: Record review of the facility policy titled “Prevention of Decline in Range of Motion” revealed “...3. Appropriate Care Planning, a. Based on the comprehensive assessment, the facility will provide interventions, exercises and/or therapy to maintain or improve range of motion...” Record review of the Care Plan Report for Resident #1 revealed “Focus: I have an ADL (activity of daily living) self-care performance deficit related to Stroke, Hemiplegia, and immobility putting me at risk for functional decline…Interventions: Apply splint to right ankle after breakfast. Provide passive stretch to right ankle after applying splint. Remove splint to right ankle at lunchtime. Apply splint to right ankle after supper. Provide passive stretch to right ankle after applying splint. Remove splint to right ankle at bedtime. Date initiated 8/1/25.	F0656		

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F0656 SS = G	Continued from page 2 Observation on 3/31/26 at 10:15 AM, revealed the resident's ankle splint was not in use and was lying in a chair in the resident's room. Interview with Resident #1 on 3/31/26 at 10:17 AM, revealed she was unsure when the splint was last applied. An interview with the Physical Therapy Assistant (PTA) on 3/31/26 at 1:10 PM revealed the resident now had foot drop and the ankle splint could not be placed without additional therapy. PTA confirmed this was related to the splint not being applied daily as ordered. Interview with the Director of Nursing (DON) on 3/31/26 at 3:40 PM, revealed the care plan was used to inform staff how to care for the resident and verified staff failed to follow the care plan when they did not apply the ankle splint. Record review of the "Admission Record" revealed that the facility admitted Resident #1 on 1/16/25 with a diagnosis of Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Right Dominant Side. Record review of Minimum Data Set Assessment (MDS) with and Assessment Reference Date (ARD) of 1/13/26 revealed a Brief Interview for Mental Status (BIMS) score of 5, indicating that the resident is cognitively impaired.	F0656		
F0688 SS = G	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility	F0688		

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F0688 SS = G	Continued from page 3 is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review the facility failed to provide services to maintain or improve Range of Motion (ROM) and prevent further decline for one (1) of three (3) resident reviewed for ROM limitations Resident #1. Findings Included: Record review of the facility policy “Prevention of Decline in Range of Motion”, date reviewed/revised 11/10/2025 revealed “Policy: Residents who enter the facility without limited range of motion will not experience a reduction in range of motion unless the resident’s clinical condition demonstrated that a reduction in range of motion is unavoidable...” Observation on 3/31/26 at 10:15 AM, revealed a foot splint lying in the chair in Resident #1’s room. Resident #1’s right hand was contracted into a fist with no hand roll in place. Interview with Resident #1 on 3/31/26 at 10:17 AM, revealed she was unsure of the last time staff had applied the splint to her foot and stated she had never had a hand roll. Interview with Licensed Practical Nurse #1 (LPN) on 3/31/26 at 10:30 AM, revealed she did not know why the splint was in the resident’s room and stated the resident was not required to wear it. She further verified the resident did not have a hand roll. Record review of the “Physician Order Summary” revealed physician orders dated 7/29/25, to apply a splint to the right ankle after breakfast and after supper with passive stretching following application. Record review of Occupational Therapy (OT) evaluation dated 2/1/25, revealed decreased ROM to the right upper extremity and recommendations for a resting hand splint and restorative splint and brace program upon discharge. Further review of OT evaluation dated 7/31/25, recommended continuation of the contracture management and splinting program. Record review of a Physician Order dated 4/24/25 revealed “Apply splint to right hand after breakfast. Provide passive stretch to right elbow, wrist, and hand after applying splint one time a day for decrease contractures…remove the splint before dinner”. Further	F0688		

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F0688 SS = G	Continued from page 4 review revealed an order dated 5/2/25 to discontinue the splint with a note “per RP (responsible party) request. States it is too painful for her mom to wear.” Interview with the Occupational Therapist on 3/31/26 at 12:30 PM, revealed she had not been notified that the hand splint had been discontinued and stated that a hand roll should have been initiated when the splint was discontinued. She further stated the resident’s hand was now contracted into a fist. Record review of Physical Therapy (PT) discharge summary dated 8/29/25, revealed the resident’s right ankle ROM improved during therapy and recommended a PODUS boot (a specialized orthopedic brace designed to treat foot drop) daily up to five (5) hours. Interview with the Physical Therapy Assistant (PTA) on 3/31/26 at 1:10 PM revealed the resident now had foot drop and the ankle splint could not be placed without additional therapy. PTA confirmed this was related to the splint not being applied daily as ordered. Interview with the Director of Nursing (DON) on 3/31/26 at 3:30 PM, verified the resident had physician orders for ankle splinting daily and stated the expectation was for staff to apply the splint to prevent decline in ROM. The DON further verified the right-hand splint was discontinued without alternative interventions to prevent contracture. Record review of the “Admission Record” revealed that the facility admitted Resident #1 on 1/16/25 with a diagnosis of Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Right Dominant Side. Record review of Minimum Data Set Assessment (MDS) with and Assessment Reference Date (ARD) of 1/13/26 revealed a Brief Interview for Mental Status (BIMS) score of 5, indicating that the resident is severely cognitively impaired.	F0688		