Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(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
M0000	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 the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm. The SA identified non-compliance and cited M 625 related to 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.	M0000		
M0625	45.21.5 Range of motion Range of motion. Residents with limited range of motion shall receive treatment and services to increase range of motion or prevent further decline in range of motion. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level III 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	M0625		

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

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M0625	Continued from page 1 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 splint before dinner". Further 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.	M0625		

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M0625	Continued from page 2 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.	M0625		