

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 09/02/2026	
NAME OF PROVIDER OR SUPPLIER MIDDLETON OAKS HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 627 MIDDLETON ROAD , WINONA, Mississippi, 38967			
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F0000	INITIAL COMMENTS The State Agency (SA) conducted six (6) Complaint Investigations (CI MS #3052535, CI MS #3075590, CI MS #3109657, CI MS # 3107120, CI MS #3109709, and CI MS # 3179879) at the facility from 9/1/26 through 9/2/26. 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 cited F684 for CI MS #3052535 and CI MS #3109657. No deficiencies were cited for CI MS #3075590, CI MS #3107120, CI MS #3179879 and CI MS #3109709. Census at the time of the survey was 91 with a bed capacity of 120 beds.			F0000			
F0684 SS = G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on record review, facility policy review and interview, the facility failed to ensure a resident who exhibited a significant increase in left lower-extremity pain received adequate nursing assessment and evaluation to identify and address the underlying cause of the pain for one (1) of 14 resident reviewed for quality of care. Resident #2. The resident experienced prolonged severe pain for approximately six weeks, requiring repeated administration of as needed (PRN) pain medication and resulting in repeated refusal of necessary care and repositioning due to pain and delayed identification of an acute displaced left femur fracture.			F0684			

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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F0684 SS = G	Continued from page 1 Findings include: Record review, on company letter head, dated 9/2/26 and signed by the Administrator revealed that the facility does not have a policy specific to assessing residents. In a telephone interview with Resident #2's Responsible Party (RP) on 9/2/26 at 9:42 AM, she reported that her mother was having a significant increase in left leg pain, and although she did not recall exactly how long she had been having it, it was at least three (3) weeks before it was addressed. She further stated that her mother yelled out in pain every time the Certified Nursing Assistants (CNA) touched her. She added that the CNAs told her they reported it to the nurse. She stated the nurses told her that when they received the reports from the CNA, they gave her pain medication. She stated that the staff never assessed her mother's entire leg or did any follow-up x-rays on anything other than her left ankle until 4/27/26, when her mother told the Nurse Practitioner (NP) about her leg pain and the NP saw that her leg was bruised and swollen. Record review of "Nursing Progress Note", dated 3/9/26, for Resident #2, revealed "Resident yelling out when staff approached her to do cares...and refused to let staff get her cleaned up... Staff asked nurse to assist, Nurse entered room to assist then resident then stated she was having pain. Nurse grabbed pain pill and pain pill was given." Record review of "Change in Condition -Situation, Background, Assessment, and Recommendation (SBAR)", dated 3/11/26, for Resident #2, revealed that she cried out in pain when her left arm/leg was touched, with pain documented at 9/10. The resident was subsequently hospitalized for unrelated clinical concerns and returned to the facility on 03/16/26. Record review of a "Nursing Progress Note", dated 03/17/26, revealed Resident #2 reported that her left knee and leg were hurting and rated the pain 10 out 10 on a pain scale of zero (0) to 10 pain scale, where 0 is no pain and 10 is the worst possible pain. The cart nurse was notified and administered pain medication. No documentation of evaluation of NP notification was noted. Record review of a "Medication Administration (MAR) Note" dated 03/17/26, revealed Resident #2 refused wound care because she was hurting too badly. The resident had received as-needed pain medication and continued to refuse the care due to pain.			F0684			

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F0684 SS = G	Continued from page 2 Record review of a "Nursing Progress Note" dated 03/19/26, revealed Resident #2 was repeatedly yelling out for help, refused for anyone to touch her, and received Norco for documented "excruciating pain" involving the left ankle and bilateral knees. Record review of a "Nursing Progress Note" dated 03/19/26, revealed Resident #2 refused to allow the nurse and aide to turn her and screamed for staff not to touch her because she was in pain. The resident was educated regarding the importance of allowing staff to provide care and the risks and benefits associated with refusing care; however, she continued to refuse to be touched. Record review of a "MAR Note" dated 03/19/26, revealed Resident #2 refused to be weighed three times, yelled and begged staff to leave her alone, and stated she was in excruciating pain. Record review of a "Nursing Progress Note" dated 03/20/26, revealed Resident #2 had refused perineal care on the previous shift and again refused care on the 7:00 AM–3:00 PM shift. The resident received pain medication before staff provided care due to complaints of pain when touched. Record review of a "Progress Note", dated 3/20/26, by the NP revealed no mention receiving report of Resident #2 having a pain level of 10 on a scale of 0 to 10. Record review of a "Progress Note", dated 3/30/26, by the NP revealed, NP evaluated complaints of left foot and ankle pain and obtained x-rays, which showed osteoarthritis. Record review of a "Progress Note", dated 4/10/26, by the NP, revealed the NP again evaluated continued complaints of left foot pain and pain with manipulation. Record review of a "Progress Note", dated 4/24/26, by the NP, revealed, staff reported a complaint of hip pain to the NP; however, during the NP's evaluation, the resident did not complain of hip pain. Left ankle: Facial grimacing with palpation and rotation; provider able to rotate ankle and touch without severe pain behaviors. Record review of a "Progress Note" dated 04/27/26, by the NP, revealed Resident #2 complained of left thigh pain. Assessment revealed a deformity that had not been identified during the NP's previous assessments. An x-ray was obtained on 04/28/26,	F0684					

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F0684 SS = G	Continued from page 3 with results received on 04/29/26 identifying an acute distal left femur fracture with anterior displacement. Resident #2 was transferred to the hospital for further evaluation. During an interview on 09/02/26 at 11:00 AM, the Director of Nursing (DON) verified that no assessment of Resident #2's left leg was documented after her complaint of a level of 10 out of 0 to 10 pain scale on 3/17/26. During an interview on 09/02/26 at 11:15 AM, the Registered Nurse (RN) Unit Manager stated Resident #2 had increased complaints of pain after her March 2026 hospitalization and verified that an assessment of the resident's left leg was not completed. Interview with Licensed Practical Nurse (LPN) #1 on 9/2/26 at 11:20 AM, she verified that the resident had increased complaints of leg pain in March and April 2026. During an interview on 09/02/26 at 11:25 AM, CNA #3 stated Resident #2 had increased complaints of left leg pain near the knee following her return from the hospital. CNA #1 stated the resident's left leg appeared more swollen than the right leg and that nursing staff were notified when the resident complained of pain. During an interview on 09/02/26 at 12:45 PM, CNA #4 stated Resident #2 complained of left leg pain following readmission, yelled out during care, and refused care. CNA #2 stated that on 03/17/26, Resident #2 yelled out in pain and complained of her left leg while being turned. Interview with LPN #2 on 9/2/26 at 1:00 PM, she verified that the Resident #2 exhibited increased complaints of pain since she had returned from the hospital in March. During an interview on 09/02/26 at 1:43 PM, the NP stated she had been notified of Resident #2's complaints of left ankle and foot pain and had assessed those areas and obtained x-rays. The NP stated she did not know about the resident's other complaints of left leg pain, including her complaint on 3/17/26, but that she would have expected staff to notify her. She stated on 4/27/26, while in the room seeing the resident's roommate, Resident #2 brought the complaint to her attention. Upon assessment, the NP observed that Resident #2's left thigh was swollen and clearly deformed. During an interview on 09/02/26 at 2:04 PM, RN #1			F0684			

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F0684 SS = G	Continued from page 4 verified that on 03/17/26 Resident #2 reported her left leg was hurting at a level of 10/10. RN #1 stated she notified the LPN floor nurse; however, she did not assess Resident #2's leg or notify the NP of the resident's increased complaint of pain. During a telephone interview on 09/03/26 at 1:22 PM, Resident #2 stated she had chronic pain but began experiencing increased left leg pain following her return from the hospital in March 2026. Resident #2 stated the pain caused her to yell out and refuse care. She stated staff administered pain medication when she complained, and although the NP evaluated her left foot and ankle the resident confirmed that her leg was not evaluated until she brought the complaint to the NP's attention on 04/27/26. Record review of the "Admission Record" revealed that the facility admitted Resident #2 on 7/14/22 with a diagnosis of Chronic Obstructive Pulmonary Disease. Record review of the Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 8/10/26 revealed a Brief Interview of Mental Status (BIMS) score of 15 indicating that Resident #2 is cognitively intact.			F0684			