STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255171	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Middleton Oaks Health and Rehabilitation	627 Middleton Road Winona, MS 38967

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on staff interview, record review, facility investigation review and facility policy review the facility failed to ensure residents were free from misappropriation of property when narcotics belonging to two residents were unaccounted for two (2) of three (3) residents reviewed for misappropriation. Resident #1 and Resident #2. Findings Include Findings Include Findings Include Review of the facility policy titled “Abuse, Neglect, Exploitation and Misappropriation” revised 11/16/22 revealed, “Policy: It is inherent in the nature and dignity of each resident at the center that he/she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, exploitation and or misappropriation of property…” Record review of the facility investigation revealed that on 8/16/25 at approximately 5:15 PM, Licensed Practical Nurse (LPN) #1 identified a discrepancy on the Controlled Drug Count Sheet. The narcotic count was altered, with numbers scratched out and rewritten, resulting in a two-card difference. Review of the narcotic count sheets documented 34 cards/packages on 8/15/25, but 31 on 8/16/25 without documentation of removal. Further review revealed that the Master List Controlled Drug form for 8/3/25 through 8/15/25 was missing. The Director of Nursing (DON) identified that Resident #1's Norco 5-325 milligrams (mg) (discontinued in March 2025 but never removed from the cart) and Resident #2's Norco 7.5-325 mg were unaccounted for. Record review of the Narcotic Count Sheet revealed the following: On 8/15/25 during the beginning of the 11:00 PM to 7:00 AM shift, 34 packages/sheets were documented on the cart and signed by LPN #3 and LPN #4. On 8/16/25 at the beginning of the 7:00 AM to 3:00 PM shift, the count numbers were marked out, and the number thirty-one (31) was written on the side, circled, and signed by LPN #4 and LPN #2. On 8/16/25 at the beginning of the 3:00 PM to 11:00 PM shift, thirty-three (33) was documented as the number of packages/sheets present. This was subsequently written over as thirty-one (31), and both entries were signed by LPN #2. (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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Master Narcotic List for the [NAME] Front Hall cart revealed no Master List Controlled Drug form was available for the period of 8/3/25 through 8/15/25. Additional review identified a Master List Controlled Drug form dated 8/16/25, which documented that one (1) empty card had been removed from the cart by LPN #4 on 8/16/25. Record review of the Order Summary Report revealed Resident #1 had an order for Norco 5-325 mg from 2/17/25 through 3/19/25. Record review of the Physician Orders revealed Resident #2 had an order for Norco 7.5-325 mg from 1/13/25 through 8/18/25. An interview with LPN #1 on 9/17/25 at 8:40 AM, revealed that narcotics are reconciled each shift by on-coming and off-going nurses, with additions or subtractions documented and witnessed. She stated that when she reconciled the cart on 8/16/25, she observed counts scratched through and a decrease from 34 to 31 without documentation of additions or removals. She reported the discrepancy to the DON immediately. An interview with LPN #2 on 9/17/25 at 9:04 AM, confirmed that she reconciled the narcotics with LPN #4 on 8/16/25 and verified the number was changed to 31 and circled but could not explain the discrepancy. She further stated that she sometimes did not check the Master List Controlled Drug form and acknowledged that Resident #1's discontinued narcotics remained on the cart. An interview with the DON on 9/17/25 at 9:30 AM, revealed she was notified of the discrepancy on 8/16/25 at approximately 5:15 PM. She confirmed that narcotics were missing, and that Resident #1's discontinued Norco and Resident #2's active Norco were not accounted for. She further stated the missing Master List Controlled Drug form could not be located. She verified that LPN #4, the nurse on duty during the shift in question, refused to assist with the investigation and was suspended on 8/17/25 and terminated on 8/21/25. An interview with the DON and Administrator on 9/17/25 at 2:30 PM, verified that a reconciliation and match back was completed on 8/16/25 of all narcotics and that corrective actions were initiated, including weekly audits implemented with continuation at least monthly and an in-service on narcotic security and misappropriation prevention. A follow-up interview with the DON and Administrator on 9/18/25 at 8:40 AM, confirmed that the incident and investigation results were presented to the Quality Assurance Committee on 8/18/25, during which the facility policy was reviewed with no revisions made. Based on the implementation of the facility's corrective actions on 8/16/25, the deficient practice was determined to be past noncompliance, and the facility was found in compliance effective 8/18/25. The SA validated on 9/18/25, through interview and record review that all corrective actions had been implemented as of 8/16/25, and the facility was in compliance as of 8/18/25, prior to the SA's entrance on 9/17/25. Record review of the “admission Record” revealed that the facility admitted Resident #1 on 10/18/23 with a diagnosis of Hypertensive Disease without Heart Failure. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the “admission Record” revealed that the facility admitted Resident #2 on 6/9/23 with a diagnosis of Cerebral Infarction.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on staff interview, record review and facility policy review, the facility failed to maintain complete and accurate medical records for one (1) of three (3) residents reviewed for post-operative care. This deficient practice resulted in the omission of a physician-ordered post-operative appointment from the resident's medical record and contributed to the resident missing the appointment. (Resident #3).Findings Include Review of the facility policy titled Physician's Orders revealed Policy The center will ensure that all physician orders are accurately documented, promptly implemented, and authenticated in the resident's medical record in accordance with Center for Medicare and Medicaid (CMS) regulations and state requirements . Record review of Resident #3's “After Visit Summary” (AVS) upon admission revealed an order for a post-operative visit on 5/6/25 at 1:00 PM with the Orthopedic Physician. Record review of Resident #3's Order Summary Report revealed an entry for an appointment on 5/20/25 at 10:15 AM with the Orthopedic Physician, with an onset date of 5/6/25. No order was documented for the 5/6/25 post-operative appointment. An interview with the Director of Nursing (DON) on 9/17/25 at 11:00 AM, revealed that Resident #3 did not attend the 5/6/25 orthopedic appointment because the order was not entered into the record. The DON stated it is facility practice that the admitting nurse enters all admission orders, and verified the resident was admitted on the 3–11 shift. The DON stated the 3–11 supervisor performed the admission and entered the orders, but the 5/6/25 appointment was missed. She further stated that she and the Assistant Director of Nursing (ADON) review admission orders in their clinical meeting the following day, but acknowledged they missed the order as well. The DON verified that the resident missed the 5/6/25 appointment due to the missed order. Record review of the “admission Record” revealed that the facility admitted Resident #3 on 4/17/25 with a diagnosis of Acquired absences of left leg below the knee.