

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375388	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/15/2025
NAME OF PROVIDER OR SUPPLIER Miami Nursing Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 East Street Northeast Miami, OK 74354	

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)
<p>F 0603</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from separation (from other residents, his/her room, or confinement to his/her room).</p> <p>(continued on next page)</p>

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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<p>F 0603</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 09/08/25 an IJ situation was determined to exist related to involuntary seclusion for 1 (#1) of 3 sampled residents reviewed for involuntary seclusion. Resident #1 was told they had to eat at a table in another room alone due to their behavior. On 09/09/25 at 2:15 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation. On 09/09/25 at 2:25 p.m., the facility administrator and the DON were notified of the IJ situation and provided a copy of the IJ template. On 09/09/25 at 5:30 p.m., an acceptable plan of removal was submitted to the Oklahoma State Department of Health. The plan of removal read in part, At 2:57pm on 9/9/2025 the DON and Care plan coordinator met with resident #1. Advised resident #1 that beginning with evening meal on 9/9/2025 she would be offered 3 locations for her meals to be taken. She could choose between main dining room, smaller dining room, or her room to have meals. Resident # 1 was agreeable to this plan. It was never the facility's intention to make resident #1 feel isolated, the facility never informed resident #1 that she had to eat alone. Facility was trying to provide alternate location for meals in a quieter setting as she self-reports that large groups or loud environments cause her to be upset. An alert has been added to EMR for resident #1 that she will be able to choose where she would like to take meals. Staff will ask resident #1 prior to each meal where she would like meal served. Care plan will be updated to reflect that resident is able to choose her dining locations. Resident #1s dietary card has been updated to reflect that meals may be taken at location of resident's choice. Facility will not ask any other resident to receive meals in small dining room unless resident requests to do so. The facility has reviewed all current residents and no other residents were identified as being secluded in any manner. In the future the facility will not seclude a resident exhibiting behavior problems that may be detrimental to other residents. If resident #1 or any other resident exhibits disruptive behaviors staff will attempt to de-escalate situation. If resident is removed from area a staff member will remain with them until behaviors have resolved. All nursing staff will receive in-service training on the above by midnight 9/9/2025. If any nursing staff is unable to be present in person they will receive in-service via phone. On 09/10/25 at 9:30 a.m., after review of the in-service records and staff interviews, the administrator and DON were informed the IJ had been removed as of 09/09/25 at 12:00 a.m. The deficient practice remained at an isolated level with the potential for minimal harm. Findings: Based on observation, record review and interview the facility failed to prevent involuntary seclusion for 1 (#1) of 3 sampled residents reviewed for involuntary seclusion. The DON identified 69 residents resided in the facility. On 09/08/25 at 12:02 p.m., Resident #1 was observed sitting alone at a table facing the wall in the day room eating lunch away from other residents. Resident #1 had a BIMS of 15 and is cognitively intact as shown in the resident's quarterly MDS Resident #1 electronic medical records shows they had diagnosis which includes lymphedema, dementia with agitation, depression, epilepsy, type 2 diabetes and asthma. On 09/08/25 at 12:02 p.m., Resident #1 stated they were told by the administrator they had to eat in the day room alone so they do not disturb anyone else. Resident #1 stated they would rather be in the dining room. It makes them feel like a child being chastised. On 09/08/25 at 3:00 p.m., CMA #1 stated Resident #1 causes chaos in the dining room. They don't like to eat with certain people. On 09/08/25 at 3:15 p.m., LPN #1 stated that for several weeks in a row Resident #1 had outbursts in the dining room. They were moved from the dining room scenario to see if things were calmer. On 09/08/25 at 3:28 p.m., the director of nurses stated Resident #1 was causing disturbances in the dining room. The director of nurses stated they were trying to find a compromise for everyone involved by moving Resident #1 to the other room. On 09/08/25 at 4:00 p.m., the administrator stated Resident #1 disrupts activities and meals. The administrator told the resident they cannot be disruptive during meal times. The administrator stated they have to look out for the other residents too. The administrator stated Resident #1 could go to the dining room as long as they were not disruptive.</p>		