STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375388	A. Building B. Wing	12/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Miami Nursing Center, LLC	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375388	A. Building B. Wing	12/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Miami Nursing Center, LLC	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interview, the facility failed to provide an environment free from abuse for 1 (#5) of 3 sampled residents whose clinical records were reviewed for abuse. The DON identified 68 residents resided in the facility. Findings:A quarterly assessment, dated 12/10/25, showed Resident #5 was moderately impaired in cognition with a BIMS score of 7, had diagnoses of non-Alzheimer's dementia, depression, and hoarding disorder; displayed verbal and physical behaviors directed toward others, and rejected care. A state reportable incident report, dated 12/10/25, showed CNA #1 accused CNA #3 (an employment agency employed CNA) of abusing Resident #5 by pinning the resident's arms behind their back and dragging the resident to a chair to sit. CNA #3 let go of the resident's arms, but grabbed the resident's wrist and squeezed. The incident report showed CNA #1 asked CNA #3 to leave. The incident report showed CNA #3 verbally antagonized Resident #5 by telling them to punch, hit, and beat the crap out of CNA #1 before CNA #3 left the room. The incident report showed Resident #5 initially claimed their arms ached all over, but soon denied any pain or discomfort and denied staff the opportunity to assess the resident for further injury. The incident report showed CNA #3 was suspended for the remainder of their shift. CNA #3 was removed from the schedule and their employment agency informed of the allegation. A witness statement signed by CNA #1, dated 12/10/25, showed three CNAs (CNA #1, CNA #2, and CNA #3) entered the resident's room to provide personal care and get the resident ready for bed. The statement showed Resident #5 approached CNA #1, grabbed, and squeezed the neck of CNA#1. CNA #1 asked CNA #3 to distract the resident by talking to them so Resident #5 would quit squeezing the neck of CNA #1. The statement showed CNA #3 had the resident's arms pinned by their back and CNA #3 used that leverage to move the resident to a chair located in the room. The statement showed CNA #1 asked CNA #3 to stop holding the resident's arms behind their back because they were hurting the resident. The statement showed CNA #3 then grabbed Resident #5 by the wrist and squeezed. The statement showed CNA #1 and CNA #2 again asked CNA #3 to stop. The statement showed CNA #3 let go of the resident's wrist and began to leave the room but stopped to verbally antagonize the resident, telling the resident to punch, hit, and beat the crap of CNA #1 and CNA #2. The statement showed Resident #5 then slapped CNA #1 across the face and began to hit CNA #1 and CNA #2 with their fist. The statement showed that after CNA #3 left the room, Resident #5 calmed and allowed CNA #1 and CNA #2 to aide them in their care. The statement showed Resident #5 complained their arms hurt all over. A witness statement signed by CNA #2, dated 12/10/25 at 10:54 p.m., showed CNA #2 attempted to aide Resident #5 in changing their brief and clothes. The statement showed Resident #5 resisted care and fought the 3 CNAs, told them to leave their room, and they would change their own brief and clothing. The statement showed as CNA #2 went to leave the room, Resident #5 walked behind them. The statement showed CNA #2 continued to encourage the resident to enter the bathroom and accept help in changing their brief and clothing. The statement showed CNA #3 grabbed the resident's pants and pulled them down, then grabbed the resident from behind, and told CNA #1 and CNA #2 to remove the resident's pants. The statement showed CNA #1 and CNA #2 instructed CNA #3 they could not force the resident to change their brief and clothing and to stop restraining the resident. The statement showed CNA #3 held the resident by their arms behind their back and pulled the resident into a chair. The statement showed the resident yelled for help and for CNA #3 to stop. The statement showed CNA #2 pleaded with CNA #3 to stop and told CNA #3 they could only coax the resident into changing their brief ,but the resident had the right to refuse and there was nothing they could do if the resident refused. The statement showed CNA #3 released the resident and the resident again instructed the CNA #1, CNA #2, and CNA #3 to leave their room. The statement showed the resident agreed to assistance with changing their brief and clothing, but then the resident repeatedly struck CNA #1 and CNA #2. The statement showed CNA #1 and CNA #2 asked CNA #3 to distract the resident so CNA #1 and CNA #2 could finish providing care to the resident while the resident was distracted. The statement showed CNA #3 held the resident down by the wrists where the resident could not move. The statement showed CNA #1 and CNA #2 were afraid the resident would get hurt and informed CNA #3 of their concerns. CNA #3 then released the resident. The statement showed the resident returned to striking CNA #1 and CNA #2 as CNA #1 and CNA #2 attempted to provide care. CNA #1 and CNA #2 again requested CNA #3 to distract the resident and CNA #3 held Resident #5 down. The statement showed CNA #1 and CNA #2 then asked CNA #3 to leave. The statement showed CNA #3 antagonized the resident by encouraging the resident to hit CNA #1 and CNA #2 as they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375388	A. Building B. Wing	12/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Miami Nursing Center, LLC	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to minimize the risk of spreading infection for 1 (#6) of 1 sampled resident exposed to COVID-19. The DON identified six residents and seven facility staff members who contracted COVID-19 since 12/01/25. Findings:On 12/12/25 at 12:35 p.m., Resident #6 was observed in their room with their roommate, Resident #5. Resident #5 was in their bed and Resident #6 was standing beside their own bed. Neither resident was wearing a mask. There were no barriers between the two residents. There were no visible signs of isolation gowns, gloves, masks used within the room, such as biohazard bags of used gowns, gloves, and masks present. Resident #6's room did not have signage for isolation on or around the resident's door and no personal protective equipment (mask, gloves, gown, etc.) was stored near the entrance to their room. On 12/12/25 at 12:40 p.m., Resident #6 exited their room and walked with their walker down to the lobby area near the front office and nurses' station. Resident #6 did not have on an isolation mask. Nursing staff were observed to pass Resident #6 in the hall and lobby area. None of the staff working on the hall with the resident were observed to wear isolation masks while in the hallway and none were observed to encourage Resident #6 to wear a mask while Resident #6 was in the hallway or ask Resident #6 to return to their room. A quarterly assessment, dated 11/30/25, showed Resident #6 was severely impaired in cognition with a BIMS score of three, exhibited no behaviors, and ambulated with a walker.A care plan, dated 11/30/25, showed Resident #6 required supervision/assistance with all decision making. A nurse's progress note, dated 12/11/25, showed Resident #6 removed isolation signage from their door and personal protective equipment basket from outside of their door. A nurse's progress note, dated 12/12/25, showed Resident #6 continued to remove signage off their door and biohazard bins from their room. A lab report, dated 12/16/25, showed Resident #6 was negative for COVID-19. On 12/12/25 at 12:35 p.m., LPN #1 stated Resident #6 resided in the same room as Resident #5. LPN #1 stated Resident #5 was in isolation for COVID-19 but Resident #6 was not in isolation and could come and go from the room as they wished. On 12/12/25 at 12:45 p.m., the DON stated Resident #5 was not part of the facility's initial COVID-19 exposure testing performed on 12/01/25. the DON stated Resident #5 tested positive for COVID-19 on 12/10/25 while out of the facility for an appointment. The DON stated on 12/10/25, Resident #6 tested negative for COVID-19 and was given the option to move to another room while Resident #5 isolated in their room or remain in the room with Resident #5 in isolation. The DON stated Resident #6 decided to remain in their room with Resident #5 in isolation. The DON stated Resident #6 would remove the isolation signs, move the isolation carts from on and around their room's door, and the biohazard containers from their room. The DON stated the facility informed Resident #6 they needed to wear a mask when they left their room, but it was the resident's right to decline to wear a mask and their right to leave their room whenever they wished.