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	02/27/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review and interview, the facility failed to ensure resident medication administration records and controlled drug count sheets accurately recorded the disposition of medications for 3 (#1, 7, and #8) of 6 sampled residents reviewed for medical record accuracy.The DON identified 19 residents at the facility were prescribed narcotics.Findings:An undated policy titled Procedure for Administration, read in part, Each dose of medication will be properly recorded in the resident's medication administration record . If the cma [sic] is unable to administer a resident medication for any reason, he/she is to notify the charge nurse immediately.1. A physician order for Res #1, dated 02/09/26, showed the resident was to be administered one Norco (opioid pain relief medication) 10-325 mg tablet every four hours as needed for pain.A MAR for Res #1, dated 02/2026, was compared to the resident's individual narcotic record, dated 01/24/26 to 02/26/26, for hydrocodone (pain medication) 10-235 mg tablets. The comparison showed the following discrepancies and missing medication destruction notations.a. On 02/09/26, the narcotic record showed four doses of the medication were administered to Res #1. The MAR on that date showed two doses were administered to the resident. There was no documentation on the individual narcotic record any of the unaccounted for tablets had been destroyed.b. On 02/10/26, the narcotic record showed five doses of the medication were administered to Res #1 and one dose was wasted. The MAR on that date showed three doses were administered to the resident. There was no documentation on the narcotic record the one unaccounted for tablet had been destroyed.c. On 02/11/26, the narcotic record showed five doses of the medication were administered to Res #1. The MAR on that date showed four doses were administered to the resident. There was no documentation on the narcotic record the one unaccounted for tablets had been destroyed.d. On 02/12/26, the narcotic record showed five doses of the medication were administered to Res #1. The MAR on that date showed four doses were administered to the resident. There was no documentation on the narcotic record the one unaccounted for tablet had been destroyed.e. On 02/13/26, the narcotic record showed five doses of the medication were administered to Res #1. The MAR on that date showed four doses were administered to the resident. There was no documentation on the narcotic record the one unaccounted for tablet had been destroyed.f. On 02/18/26, the narcotic record showed five doses of the medication were administered to Res #1. The MAR on that date showed four doses were administered to the resident. There was no documentation on the narcotic record the one unaccounted for tablet had been destroyed.g. On 02/19/26, the narcotic record showed five doses of the medication were administered to Res #1. The MAR on that date showed four doses were administered to the resident. There was no documentation on the narcotic record the one unaccounted for tablet had been destroyed.h. On 02/20/26, the narcotic record showed five doses of the medication were administered to Res #1. The MAR on that date showed three doses were administered to the resident. There was no documentation on the narcotic record any of the unaccounted for tablets had been destroyed.On 02/20/26 at 2:40 p.m., Res #1 stated they kept track of when they took their pain pills. They stated (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	02/27/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	when they had the opportunity to compare their notes to the facility's narcotic records, the narcotic records were not accurate.2. A physician order for Res #7, dated 02/03/26, showed the resident was to be administered one Ativan (antianxiety medication) 1mg tablet at bedtime.A MAR for Res #7, dated 02/2026, was compared to the resident's narcotic record, dated 02/06/26 to 02/25/26, for Ativan 1mg tablets. The comparison showed the following discrepancies and missing medication destruction notations.a. On 02/06/26, the narcotic record showed one dose of the medication was administered to Res #7. The MAR on that date showed one dose of the medication had been refused by the resident. There was no documentation on the narcotic record of the refused tablet had been destroyed.b. On 02/07/26, the narcotic record showed one dose of the medication was administered to Res #7. The MAR on that date showed one dose of the medication had been refused by the resident. There was no documentation on the narcotic record of the refused tablet had been destroyed.c. On 02/08/26, the individual narcotic record showed one dose of the medication was administered to the Res #7. The MAR on that date showed one dose of the medication had been refused by the resident. There was no documentation on the individual narcotic record of the refused tablet had been destroyed.d. On 02/09/26, the narcotic record showed one dose of the medication was administered to Res #7. The MAR on that date showed one dose of the medication had been refused by the resident. There was no documentation on the narcotic record of the refused tablet had been destroyed.e. On 02/10/26, the narcotic record showed no medication was signed out for that date. The MAR on that date showed Res #7 was administered the one medication that was ordered.f. On 02/14/26, the narcotic record showed one dose of the medication was administered to Res #7. The MAR on that date showed one dose of the medication had been refused by the resident. There was no documentation on the narcotic record of the refused tablet had been destroyed.g. On 02/15/26, the narcotic record showed one dose of the medication was administered to Res #7. The MAR on that date showed one dose of the medication had been refused by the resident. There was no documentation on the narcotic record of the refused tablet had been destroyed.h. On 02/21/26, the narcotic record showed one dose of the medication was administered to Res #7. The MAR on that date showed one dose of the medication had been refused by the resident. There was no documentation on the narcotic record of the refused tablet had been destroyed.i. On 02/22/26, the narcotic record showed one dose of the medication was administered to Res #7. The MAR on that date showed one dose of the medication had been refused by the resident. There was no documentation on the narcotic record of the refused tablet had been destroyed.j. An undated entry on the narcotic record (immediately below the entry for 02/24/26) showed one dose of the medication was administered to the Res #7. The MAR showed on 02/25/26, one dose of the medication had been refused by the resident. There was no documentation on the narcotic record of the refused tablet had been destroyed.3. A physician order for Res #8, dated 06/03/24, showed the resident was to be administered two tramadol (opioid pain relief medication) 50 mg tablets every six hours as needed for pain.A MAR for Res #8, dated 02/2026, was compared to the resident's narcotic record, dated 06/03/24 to 02/25/26, for tramadol 50 mg tablets. The comparison showed on 02/12/26, two tramadol 50 mg tablets had been administered to Res #8 on the narcotic record. The MAR showed no doses of tramadol were documented as being administered to the resident on that date. There was no documentation on the individual narcotic record of the tablets had been destroyed.On 02/26/26 at 2:15 p.m. CMA #1 stated when a medication was refused by a resident, the CMA and the nurse were supposed to initial next to the entry on the count sheet and that would indicate the pill was destroyed.On 02/26/26 at 2:23 p.m., LPN #1 stated when a resident refused a controlled medication, the person attempting to administer the medicine was to go to their nurse with the medicine. They stated the nurse and the other person destroy the medication together and both initial on (continued on next page)

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	02/27/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the count sheet next to the entry to indicate it was destroyed.On 02/27/26 at 8:19 a.m., RN #1 observed the 02/2026 MARs and narcotic records for Residents #1, 7, and #8. They stated each of the documents were not accurate and showed pills had been signed out but there was no documentation they were administered or destroyed. They stated they were not aware the CMAs were not telling the nurse when a resident had refused a controlled medication. They stated they were supposed to notify the nurse and then destroy the medication together.On 02/27/26 at 8:28 a.m., CMA #2 observed the 02/2026 MARs and narcotic records for Residents #1, 7, and #8. They stated each of the documents were not accurate and showed pills had been signed out but there was no documentation they were administered or destroyed. They stated all refused controlled medication were supposed to be taken to the charge nurses by the CMA and destroyed together. They stated both then initial next to the entry on the count sheet to indicate the medication was destroyed.On 02/27/26 at 8:50 a.m., CMA #1 observed the 02/2026 MARs and narcotic records for Residents #1, 7, and #8. They stated each of the documents were not accurate and showed pills had been signed out but there was no documentation they were administered or destroyed. CMA #1 stated they had just learned about the process of taking refused medications to the charge nurse on 02/26/26. They stated previous to 02/26/26 they had been destroying the medication by themselves and had not alerted the charge nurses.On 02/27/26 at 9:03 a.m., the DON stated some of the CMAs had not been following procedure to alert the charge nurses of refused narcotics. They stated nurses must be informed of refused medications and the CMA and nurse must destroy the medication together and sign off on the narcotic record.