| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375388 | A. Building<br>B. Wing | 08/14/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Miami Nursing Center, LLC | 1100 East Street Northeast<br>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.

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>Based on record review and interview, the facility failed to ensure an advance directive was offered to 1 (#30) of 1 sampled resident reviewed for advance directives.The DON identified 69 residents resided in the facility.Findings: A quarterly assessment, dated 05/19/25, showed a BIMS of 15 which indicated Resident #30 was cognitively intact for daily decision making. The assessment showed diagnoses which included neurogenic bladder and quadriplegia. Review of the clinical record showed no advance directive acknowledgement to indicate Resident #30 had been offered an opportunity to develop an advanced directive. On 08/11/25 at 4:28 p.m., the DON was asked to provide an advance directive acknowledgement for Resident #30. On 08/12/25 at 7:52 a.m., the DON stated they did not find an advance directive acknowledgement for Resident #30. An advance directive acknowledgement was not provided for Resident #30 by the end of the survey. |

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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>Based on observation, record review and interview, the facility failed to notify of a room change for 1 (#3) of 1 sampled resident reviewed for notification of change.The DON identified 69 residents resided in the facility. Findings: On 08/12/25 at 9:00 a.m., Resident #3 was observed to have been moved to another room. An undated facility document titled Policy and Procedure for Notification of Change, read in part, Except in a medical emergency or when a resident is incompetent, this facility will consult with the resident immediately and notify the resident's physician, and if known, the resident's legal representative or interested family member within 24 hours when there is .a change in room or roommate assignment (said notice shall include cost of transferring resident's telephone, if applicable). Review of clinical progress notes for Resident #3 showed no notification was made to a representative regarding a room change. A quarterly assessment, dated 07/07/25, showed a BIMS of 00, which indicated Resident #3 was severely impaired for daily decision making. The assessment showed diagnoses which included heart failure, hypertension, cerebrovascular accident, and seizure disorder. A facility Notice of Room or Roommate Change form, dated 08/10/25, provided by the DON, showed it was for a room change and had no documented reason for a room change. The form showed a scribble mark for a resident's signature with the nurse's printed name below the resident's scribble mark. On 08/12/25 at 9:36 a.m., the DON stated Resident #3 was moved over the weekend to another room. They stated notification should have been made prior to the move and documented in the clinical record. The DON stated Resident #3 had been moved to accommodate another resident's request due to an issue with their roommate. On 08/12/25 at 10:39 a.m., the representative of Resident #3 stated they were not made aware of the move for Resident #3 until Monday 08/11/25 after Resident #3 had been moved. They stated the facility did not ask. The representative stated the facility called them and told them they had moved Resident #3. |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure unnecessary psychotropic medications were not administered to 1 (#74) of 5 sampled residents reviewed for unnecessary medications.The DON identified 57 residents received psychotropic medications in the facility.Findings: An admission record showed Resident #74 admitted to the facility on [DATE] and had diagnoses which included dementia, anxiety disorder, and post-traumatic stress disorder. A minimum data set assessment had not been completed and a BIMS was not established. A physician's order, dated 08/04/25, showed to administer Risperdal (an antipsychotic) 1 mg one tablet by mouth at bedtime related to dementia unspecified severity with other behavioral disturbance. A physician's order, dated 08/06/25, showed to administer Risperdal 0.5 mg one tab by mouth at bedtime related to dementia unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety for 14 days. The order had an end date of 08/20/25. A review of the August 2025 medication administration record showed Risperdal 0.5 mg was not administered on 08/06/25 and was to be on held on 08/07/25 and 08/08/25. On 08/11/25 at 2:07 p.m., Resident #74 stated they did not know why they were taking Risperdal. They stated they did not want the facility to give them that medication. On 08/11/25 at 2:18 p.m., the DON stated Resident #74 came to the facility from a geriatric psychiatric hospital. They stated the Risperdal was a medication the facility would try to get Resident #74 off of due to an inaccurate diagnosis. The DON stated the nurse practitioner wrote an order on 08/06/25 to decrease the Risperdal to 0.5 mg, but the nurse did not discontinue the 1 mg Risperdal order. They stated Resident #74 received both the 1 mg and 0.5 mg Risperdal over the weekend. The DON stated the Risperdal 1 mg was an unnecessary medication. |

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| F 0697<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Provide safe, appropriate pain management for a resident who requires such services.<br><br>On 08/12/25 an Immediate Jeopardy (IJ) situation was determined to exist related to pain management during wound care for 1 (#27) of 4 sampled residents reviewed for pain.On 08/13/25 at 1:00 p.m., the OSDH was notified and verified the existence of the IJ situation. On 08/13/25 at 1:39 p.m., the facility administrator and DON were notified of the IJ situation and provided a copy of the IJ template. On 08/13/25 at 5:20 p.m., an acceptable plan of removal was submitted to the OSDH. The plan of removal read in part, a pain assessment was completed on Resident #27 at 3:00 p.m., on 08/13/25. PCP [primary care physician] for Resident #27 was contacted and a new order for Tramadol, an analgesic, was obtained. Staff will offer PRN [as needed] pain medication approximately 30 minutes prior to wound care. Care plan for Resident #27 will be updated accordingly. For all other residents a new pain assessment will be completed by 12:00 p.m., tomorrow (08/14/25). All employees will be in-serviced on pain management including recognition of pain (verbal and non-verbal signs) by midnight 08/13/25. If employee is unable to come in person for training they will receive training over the phone and then in person training prior to the beginning of their next shiftOn 08/14/25 at 3:30 p.m., the administrator and the DON were informed the IJ had been removed as of 08/14/25 at 12:00 p.m., when all components of the plan of removal had been completed. On 08/14/25 interviews were conducted with a total of 14 employees who worked different shifts in the nursing department. The employees verified they had been in-serviced regarding the components documented in the plan of removal and that they understood the information. The deficiency remained at an isolated level with the potential for more than minimal harm.Based on observation, record review and interview the facility failed to assess, monitor, and intervene for pain for 1 (#27) of 4 sampled residents reviewed for pain. The DON identified four residents with wounds.Findings:On 08/12/25 at 1:14 p.m., during wound care, Resident #27 was observed grimacing, stiffening, and stated Ow, Ow!. LPN #1 did not stop the wound care or address Resident #27's pain. An undated policy titled Policy and Procedure for Pain Identification and Treatment, read in part, It is the policy of this facility to identify the presence of pain in residents and to implement treatment strategies in an effort to alleviate or minimize pain, consistent with the resident's goals, while assisting the resident to maintain a high level of functioning as possible and to maintain or improve his/her quality of life.A medical diagnosis list, dated 06/12/25, showed Resident #27 admitted to the facility with diagnoses which included type 2 diabetes, Alzheimer's disease, peripheral vascular disease and hypertension. A pain assessment form dated 06/30/25 showed the resident did not have pain at that time. An entry assessment dated , 07/30/25, showed Resident #27 had a BIMS score of 5 and was severely cognitively impaired.A wound care order, dated 08/02/25, read in part, Apply gentian violet solution [antiseptic to treat skin infections] to amputated surgical incision on right foot, coccyx, and to right heel topically every shift for wound care. Clean wound with normal saline, pat dry, apply with sterile cotton tip applicator gentian violet to wound bed, leave open to air. The treatment administration record showed from 8/02/25 through 08/12/25 the resident had not been assessed for pain during wound care for 35 missed opportunities. On 08/12/25 at 3:20 p.m., LPN #1 stated they had not assessed Resident #27 for pain prior to wound care of the coccyx. LPN #1 stated they did not know if Resident #27 had medication ordered for pain. LPN #1 stated they should have stopped the wound care when Resident #27 voiced they were in pain. LPN #1 stated they did not know why they did not stop, and it was wrong.On 08/13/25 at 8:08 a.m., CNA #1 stated Resident #27 exhibits pain with wound care. CNA #1 stated they clinched their teeth and sometimes they moaned.On 08/13/25 at 8:34 a.m., CNA #2 stated Resident #27 has pain during wound care. CNA #2 stated they tensed up and sometimes yelled out or would tell them not to do wound care because it hurt.On 08/13/25 at 11:03 a.m., Resident #27 stated they had pain every time wound care was done. They stated their pain was an 8 on a scale of 1 to 10.On 08/13/25 at 4:03 p.m., the DON stated they did not know why Resident #27 did not have pain medication ordered. |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.<br><br>Based on observation, record review, and interview, the facility failed to ensure nurses were competent in identifying and assessing pain during wound care for 1 (#27) of 4 sampled residents reviewed for wound care.The DON identified four residents had wounds in the facility.Findings: On 08/12/25 at 1:14 p.m., during wound care, Resident #27 was observed to grimace, stiffen their body, and stated Ow, Ow!. LPN #1 was observed to not stop the wound care or address Resident #27's pain. Review of employee files did not show training was completed for wound care.On 08/12/25 at 3:20 p.m., LPN #1 stated they had not assessed Resident #27 for pain prior to wound care. They stated they did not know if Resident #27 had medication ordered for pain. LPN #1 stated they should have stopped the wound care when Resident #27 voiced they were in pain. They stated they did not know why they did not stop and it was wrong.On 08/14/25 at 12:55 p.m., the DON stated they did not know if they had a specific way to ensure the nurses were competent in identifying and treating wounds. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, record review, and interview, the facility failed to:ensure opened containers in the reach in refrigerator were properly labeled; andensure the top of the oven was free of grime and debris. The DON identified 65 residents received meals prepared in the kitchen.Findings:On 08/06/25 at 10:00 a.m., a tour of the kitchen was conducted. The following observations were made:a. an opened gallon container of orange drink, an opened 48-ounce container of grape juice, an opened 48-ounce container of prune juice, and an opened 46-ounce container of thickened lemon water were observed in the reach in refrigerator. None of the open containers were labeled with the date they were opened, andb. the top of the oven was covered with debris and the walls above the oven were coated with sticky brown substance.An undated facility policy titled Refrigerated Storage, read in part, The opened unused portions of packaged foods should be dated to ensure they are used first.An undated facility policy titled Cleaning schedules showed the oven and the walls should be cleaned weekly.On 08/06/25 at 10:55 a.m., dietary aide #1 stated once items were opened, they should be labeled with the date they were opened.On 08/11/25 at 11:09 a.m., the dietary manager stated they were new and not aware opened items in the reach in cooler were supposed to be labeled with the date they were opened. They stated the oven and the area around it should be thoroughly cleaned. |

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| F 0838<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies.<br><br>Based on record review and interview, the facility failed to ensure a facility assessment included residents with wounds and the training and competency required to treat wounds.The DON identified four residents with wounds resided in the facility.Findings: A Facility-Wide Assessment, reviewed 07/30/25, did not address residents with wounds in the facility. The assessment did not address training and competency for staff regarding wounds. On 08/14/25 at 12:53 p.m., the administrator was asked why the facility assessment did not address wounds in the facility. They stated, That is something we will add to that. The administrator was asked why the facility assessment did not address wound training. They stated, We will take care of that immediately. |

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| F 0940<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop, implement, and/or maintain an effective training program for all new and existing staff members.<br><br>Based on record review and interview, the facility failed to ensure training was provided for staff on wound care.The DON identified four residents had wounds in the facility.Findings: A Facility-Wide Assessment, reviewed 07/30/25, did not address training and competency regarding wound care for residents with wounds. Review of employee records did not show employees were trained and competent in wound care. On 08/14/25 at 12:55 p.m., the DON stated they did not know if they had a specific way to determine nurses were competent in identifying and treating wounds. |