

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375548	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Ayers Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 801 B Street Snyder, OK 73566	
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 - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on record review and interview, the facility failed to protect a resident from verbal abuse for 1 (#1) of 3 sampled residents reviewed for staff abuse. The DON identified 72 residents resided in the facility. Findings: A policy titled Resident Abuse and Neglect Policy and Procedure, dated 02/24/20, read in part, ensure all residents are free from mistreatment, neglect, abuse .reporting, recognizing, and free from reprisal .recognize burnout, frustration or stress related issues .how and whom they may report concerns to, such as incidents and grievances without fear of retribution .no staff member is exempt from being reported. A final incident report, dated 07/20/26, showed an abuse allegation against LPN #1. The report showed LPN #1 was yelling and screaming at Resident #1 who had spit in the face of CNA #1. As of Monday, 07/20/26, after LPN #1 had completed their shift, they were placed on suspension. On 07/23/26 staff were educated on the importance of protecting residents from abuse by staff, other residents, family, and any other visitor. The report showed staff were advised they could go to the administrator or DON anytime. If the staff felt like there could be retaliation they were to report it. On 07/21/26 a written statement from Resident #2, read in part, LPN #1 liked to argue with them and really just seemed kind of rude. No bedside manner. On 07/22/26 a written statement from Resident #11, read in part, heard LPN #1 yelling, but did not who it was, but that person was being told they could go to jail for that shit. On 7/22/26 at 1:27 p.m., the administrator stated when CNA #1 went around the corner with Resident #1, the resident was saying hateful things and spit in the face of CNA #1. The administrator stated LPN #1 got up and told Resident #1 it was unacceptable. They stated a lot of people heard LPN #1 yelling at Resident #1. On 07/24/26, a written statement from Resident #6, read in part, [LPN #1] seemed cranky and got verbal with Residents. On 07/24/26, a written statement from Resident #12, read in part, [LPN #1] was always rude to me .I heard them yelling a few nights ago, but I don't know who or what is was about. On 07/24/26, a written statement from Resident #13, read in part, [LPN #1] was mean to me .that's how they thought it was supposed to be. On 07/29/26 at 9:44 a.m., an anonymous resident stated they had heard LPN #1 speak hateful to residents at night. On 07/29/26 at 2:45 p.m., the power of attorney for Resident #1 stated they thought the situation on 07/20/26 was handled exceptionally well. They stated, I was thankful, that's why I put them over there because I knew they would take care of them. On 07/29/26 at 4:03 p.m., LPN #1 stated the morning of 07/20/26, CNA #1 was ambulating Resident #1 with their rolling walker to the shower room. LPN #1 stated Resident #1 started calling CNA #1 names and spit on them. LPN #1 stated as charge nurse, I tried to intervene and deescalate the situation. LPN #1 stated their hands were on the u-shaped bar of the rolling walker, leading Resident #1 into the shower room. LPN #1 stated, I did not touch [them] once. LPN #1 stated they had bent forward trying to get eye level with Resident #1 so they could see them. LPN #1 stated they told Resident #1 they could not be doing that. On 07/30/26 at 5:07 a.m., CNA #1 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
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN #1 told Resident #1, You can not spit on my staff like that. That is against the law. You could go to jail for that. It will not be tolerated. CNA #1 stated it sounded like scolding. CNA #1 stated LPN #1 asked them to close the door then stated to Resident #1, We're not in the view of the camera now [explicit language]. On 07/30/26 at 7:29 a.m., housekeeper #1 stated they overheard LPN #1 state, We're no longer in camera view. CNA #1 shut the door. On 07/30/26 at 7:36 a.m., the housekeeping supervisor stated at the shower room CNA #1 and LPN #1 were talking and Resident #1 told them to shut up. LPN #1 told Resident #1 they would not talk to anyone like that and look at me when I'm talking to you. On 07/30/26 at 8:46 a.m., the DON stated the owner, administrator, and themselves had asked during the resident council about abuse for feedback, but no resident had any complaints. The stated, The administrator had interviewed a lot of them. On 07/30/26 at 9:09 a.m., the administrator was asked about the outcome of their investigation. They stated they had spoken with the owner and from everything they investigated and reviewed as a team, there was a problem with LPN #1. The administrator stated residents and staff were scared of LPN #1, but nobody said anything. On 07/30/26 at 11:09 a.m., CNA #3 stated they heard LPN #1 yelling. They knocked on the shower door and opened the door. LPN #1 was standing in front of Resident #1 and their walker with their hands on the bilateral wrists of Resident #1. They asked, Do I need to strip their bed? LPN #1 stated, Yeah you're going to strip their [explicit language] bed because they're not going back to [explicit language] in bed. CNA #3 stated LPN #1 slapped the hand of Resident. LPN #1 was yelling at Resident #1.		