STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375548	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ayers Nursing Home	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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41873 Based on record review and interview, the facility failed to ensure diagnosis of a serious mental illness was reported to the OHCA for a level II PASRR evaluation for two (#3 and #48) of three sampled residents reviewed for PASRR. The DON identified 69 residents resided in the facility. Findings: An undated facility PASRR policy, read in part, Upon the receipt of a referral the designated staff will review the diagnosis and medication of the possible admission .If it is determined the referral requires a Level II PASRR due to a diagnosis and/or use of anti-psych meds, a Level II PASRR is initiated and transmitted to OHCA to determine approval for admission to LTC . 1. Res #3 was admitted to the facility on [DATE]. A Level I PASRR screen, dated 06/11/19, documented no diagnosis of a serious mental illness. Res #3's admission record, dated 08/31/22, documented on 05/07/21 the resident has a diagnosis of recurrent major depressive disorder, and on 05/13/21 the resident had a diagnosis of bipolar disorder. On 09/18/24 at 9:55 a.m., the DON and RN Consultant reported they did not have a policy for completing the PASRR screen. They stated staff had not contacted OHCA when resident #3 was diagnosed with new mental illness of recurrent major depressive disorder and bipolar disorder. 2. Res #48 was admitted to the facility on [DATE]. A Level I PASRR screen, dated 09/21/21, documented no diagnosis of a serious mental illness. Res #48's admission record, dated 09/21/21, documented on 09/13/21 the resident had diagnoses of recurrent major depressive disorder, anxiety disorder, and unspecified psychosis. (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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/19/24 at 9:34 a.m., the MDS Coordinator stated they were not aware a diagnosis of major depressive disorder would be considered a serious mental illness. They stated it should have been recorded on the PASRR Level I screen. On 09/19/24 at 9:42 a.m., the BOM stated resident #48's diagnosis of major depressive disorder should have been included on their 09/21/21 Level I PASRR screen.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34333 Based on observation, record review, and interview, the facility failed to provide assessment and monitoring before and after dialysis treatments, and maintain ongoing communication with the dialysis center for one (#13) of one sampled resident reviewed for dialysis. The DON identified one resident who received dialysis treatments. A Policy for Care of Dialysis Residents in LTC Setting, dated September 2024, read in part, Purpose: To set a policy that will establish guidelines for best practices for End Stage Renal Disease and (ESRD)-Specific Resident care for dialysis residents. Our goal is to efficiently and effectively increase the quality of care of life for ESRD residents. We are focused on promoting resident-centered care, as well as resident and family engagement at the highest level possible. Findings: Res #13 was admitted to the facility on [DATE] with diagnoses which included chronic kidney disease stage 5, type 2 diabetes mellitus, retention of urine, and edema. A care plan, dated 02/28/23, documented the resident required dialysis related to renal failure. It was documented the facility would provide transportation and encourage the resident to go for scheduled treatments. It was documented to monitor the shunt to left forearm and palpate for thrill twice a day and as needed. It was documented the resident had a communication problem related to hearing deficit and unclear speech at times. An MDS assessment, dated 08/30/24, documented the resident was moderately impaired with cognition. It was documented the resident required dialysis treatments. On 09/16/24 at 11:27 a.m., resident #13 stated they went for dialysis treatments on Tuesday, Thursday, and Saturday. The resident's shunt was observed and they confirmed the dialysis center accessed it for treatments. On 09/17/24 at 3:15 p.m., RN #3 stated staff obtained the resident's vital signs on the day of dialysis and the nurse assessed the shunt for a thrill. The RN stated the resident was assessed and weighed at the dialysis center. The RN stated once a month the dialysis unit would draw labs and send the lab results back with the resident, along with any recommendations or requests for orders. The RN stated the nurse practitioner at the dialysis unit occasionally called the facility on Fridays to check in or make the facility aware of any changes. The RN stated they did not document on a communication form or share information with the dialysis unit, unless the dialysis unit called the facility to give a report. On 09/18/24 at 9:36 a.m., the DON stated the nurses obtained vital signs before and after resident #13 went to dialysis, but stated they did not have anything in place to ensure ongoing communication with the dialysis center before and after treatments.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 30875 Based on observation, record review, and interview, the facility failed to ensure a medication rate of less than 5%. A total of 31 opportunities were observed during the medication pass with two errors identified. The total medication error rate was 6.45% related to two medications crushed without physician orders to crush the medications for two (#23 and #62) of nine sampled residents reviewed for medications. The administrator identified 69 residents resided in the facility. Findings: An undated document titled Drugs that should not be chewed or crushed, read in part, .Potassium Chloride . Enteric coated tablet designed to pass through the stomach whole and then dissolve in the intestines . Reasons for this type of formulation include: 1a. to prevent the destruction of the drug by stomach acid. 1b. to prevent irritation to the stomach. 1c. to achieve prolonged action . 1. Res #23's physician orders, dated 07/31/24, documented potassium chloride ER tablet 20 mEq. Give one tablet by mouth one time a day for supplement. The physician orders did not include an order to crush medications. On 09/17/24 at 8:20 a.m., a medication pass was conducted with ACMA #2. The ACMA administered one potassium chloride ER 20 mEq tablet to resident #23. They stated they were crushing their medication and mixing it with pudding. They stated the resident had thickened liquids with their meal. 2. Resident #62's physician orders, dated 09/09/24, documented potassium chloride ER tablet 20 mEq. Give one tablet by mouth one time a day for supplement. The physician orders did not include an order to crush medications. On 09/17/24 at 8:40 a.m., a medication pass was conducted with ACMA #2. They administered one potassium chloride ER 20 mEq tablet to resident #62. They stated they were crushing their medication and mixing it with pudding. On 09/17/24 at 3:02 p.m., the RN consultant stated the physician orders did not contain crush orders for resident #23 and resident #62. They stated the potassium chloride should not be crushed.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 34333 Based on record review and interview, the facility failed to submit payroll based staffing information to CMS as required for the 3rd quarter of 2024. The administrator identified 69 residents resided in the facility. Findings: A PBJ Staffing Data Report - FY Quarter 3 2024, documented there was no data submitted for the third quarter. On 09/17/24 at 11:51 a.m., the BOM stated the staffing report for the 3rd quarter of 2024 had not been submitted to CMS as required.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 34333 Based on observation, record review, and interview, the facility failed to have EBP in place for two (#13 and #57) of three sampled residents reviewed for infection prevention and control. The DON identified three residents who required EBP. Findings: The facility's infection control policy was reviewed and contained no documentation or guidance related to EBP. On 09/16/24 at 9:00 a.m., a tour of the facility was conducted. There was no signage or PPE supplies observed in place for residents who required EBP. On 09/16/24 at 3:15 p.m., the consulting RN stated they were not aware of the EBP requirement. They stated the facility did not have a policy or process in place. On 09/17/24 at 8:38 a.m., wound care was provided for resident #57. Nursing staff were observed to don PPE appropriately related to EBP. The staff stated they were not aware of EBP requirements. On 09/18/24 at 2:06 p.m., RN #1 was observed to provide catheter care for resident #13. The RN was observed to don gloves and a gown prior to care. The RN was asked if they were using EBP previously. They stated they were not. They stated they did not know anything about the requirement.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. 41873 Based on observation and interview, the facility failed to ensure emergency call systems located near toilets were accessible by a resident lying on the floor in nine of 11 community bathrooms frequently used by residents. The DON stated 69 residents resided in the facility. Findings: On 09/18/24 at 1:40 p.m., community bathrooms used by residents were observed. Nine of the 11 bathrooms were observed to have a small switch on the wall near the toilet to activate the emergency call system and would not be accessible to a resident lying on the floor. 09/18/24 1:51 p.m. the DON stated not all the community bathrooms used by residents had a pull cord attached to the emergency call system switch near the toilet. They stated the emergency call system switch located near the toilets in the community bathrooms would not be accessible to a resident lying on the floor. The DON stated they did not know the reason all the call systems near the toilets were not equipped with a pull cord and the maintenance supervisor was on vacation. On 09/18/24 at 2:16 p.m., the DON stated the facility had no policy related to emergency call systems. They stated the administrator stated all emergency call systems in bathrooms used by residents had previously been equipped with pull cords and they were unsure of when they were removed.