STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375289	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Artesian Home	1415 West 15th Street Sulphur, OK 73086

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, and interview, the facility failed to ensure food was prepared and served in a sanitary manner to minimize the risk of infection/cross contamination during 3 of 3 meal preparation and service observations. The dietary manager identified 50 residents received nutrition from the kitchen. Findings: On 05/05/26 11:45 a.m., the dietary manager was observed with visible facial hair performing tasks without wearing a beard guard. The dietary manager was observed to place grocery items in the refrigerator, then began to help with preparing lunch meals. A Food Distribution and Service policy, revised 10/2017, read in part, Food and nutrition services staff wear hair restraints (hair net, hat, beard restraint, etc.) so that hair does not contact food. On 05/05/26 at 11:45 a.m., the dietary manager stated, they believe the policy said if a person could pull and tug on their facial hair a beard guard must be worn. On 05/06/26 at 11:50 a.m., the regional registered nurse stated if staff have facial hair and are preparing or serving food, they must wear a beard guard. They stated, The staff knows the policy.

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 Level of Harm - Minimal harm or potential for actual harm 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. Based on record review and interview, the facility failed to ensure a resident's family member was notified of a medication change and a urinary tract infection for 1 (#1) of 1 sampled resident reviewed for notification of change.The DON identified 17 residents had urinary tract infections in the past three months.Findings:A facility document titled Change in a Resident's Condition or Status, dated February 2021, read in part, Our facility promptly notifies the resident, his or her attending physician and the resident representative of changes in the resident's medical /mental and or status (e.g. [for example], change in level of care, billing/payments, resident rights, etc.).A progress note for Resident #1, dated 04/21/26, showed new physician orders of an antibiotic medication were received with the diagnosis of an UTI and prescribed Augmentin. The progress note did not show Residents #1's family member was notified.On 05/06/26 at 10:09 a.m., family member #1 stated they were not notified when Resident #1 had a UTI and was prescribed a new medication.On 05/07/2026 at 11:21 a.m., LPN#1 stated Resident #1's family member should have been notified of the UTI and new medication. LPN #1 stated the notification should be documented in the medical record.On 05/07/2026 at 11:24 a.m., the ADON stated Resident #1's family member should have been notified of the UTI and new medication. The ADON stated the change in condition should be documented in the medical record.

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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 ensure EBP were followed during urinary catheter care for 1 (#36) of 1 sampled resident reviewed for urinary catheters.The DON identified one resident with a urinary catheter resided in the facility.Findings:On 05/06/26 at 2:50 p.m., LPN #1 was observed to perform urinary catheter care for Resident #36. LPN #1 washed their hands, used hand gel, and applied gloves to perform urinary catheter care. LPN #1 was not observed to wear a gown.An Enhanced Barrier Precautions policy, dated 12/01/24, read in part, Enhanced barrier precautions apply when a resident is not known to be infected or colonized with any multi drug resistant organisms, has a wound, or has indwelling medical devices.indwelling medical devices include urinary catheters.Enhanced barrier precautions employ targeted gown and glove use in addition to standard precautions during high-contact resident care activities. A physician's order for Resident #36, dated 05/09/25, showed urinary catheter care every shift.An annual assessment for Resident #36, dated 02/17/26, showed the resident's cognition was intact with a brief interview for mental status score of 15. The assessment showed Resident #36 was dependent on staff for activities of daily living. The assessment showed Resident #36 had an indwelling urinary catheter and a diagnosis of neurogenic bladder.A care plan for Resident #36, dated 02/16/26, read in part, The resident requires EBP due to the presence of urogenital implants and a suprapubic catheter.Utilize gown and gloves/PPE [personal protective equipment] during care as indicated.On 05/06/26 at 2:55 p.m., LPN #1 stated enhanced barrier precautions for urinary catheter care should include wearing gloves and a gown. LPN #1 stated a gown should have been worn for Resident #36's urinary catheter care. LPN #1 stated they forgot to put a gown on because enhanced barrier precautions were not hanging on Resident #36's door.On 05/08/26 at 11:50 a.m., the ADON/infection preventionist stated staff should have worn a gown and gloves to perform Resident #36's urinary catheter care as part of enhanced barrier precautions.