STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375490	A. Building B. Wing	02/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marlow Nursing & Rehab	702 South 9th Marlow, OK 73055

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 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. 30875 Based on record review and interview, the facility failed to: a) notify the resident representative on file for one (#2) of two sampled residents reviewed for change in condition; and b) failed to notify physician for one (#1) of one sampled resident with an abnormal temperature at the time of admission. The administrator identified 42 residents resided in the facility. Findings: 1. Res #2 had diagnoses which included high blood pressure, diabetes, and bradycardia. A nurse note, dated 11/21/23, documented the resident was lethargic with an O2 oxygen saturation of 88% on room air, heart rate of 51 and blood pressure of 117/72 and was hunched over in the wheelchair. The note documented the PA was notified and called the ambulance to send them out to the hospital, they left with the resident at 7:28 a.m. The note documented a family member who was listed as the resident's second contact and left a message. A Patient Transfer Form dated 11/21/23, documented the date of the transfer as 11/21/23, facility name and address, transferring to hospital, and relative or guardian as the resident's second contact person. The face sheet located in the resident's clinical record did not list anyone as the responsible party, it listed a second contact person and phone number, and listed a third contact person without a phone number. A Durable Power of Attorney for Resident #2, on file at the facility listed the third contact person's name as the resident's DPOA. The responsible party listed on the document located in the business office files was the person named as the Durable Power of Attorney. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/02/24 at 9:35 a.m., the DPOA reported the facility did not contact them on 11/21/23 related to Res #2's transfer to the hospital. On 02/02/24 at 10:10 a.m., the corporate RN was asked about Res #2's responsible party. They returned with the DPOA paperwork and identified them as the responsible party and reported they should have notified them. The corporate RN reported it was the facility policy to notify the family/representative when a resident was transferred to the hospital. 2. A Resident Examination and Assessment policy, dated February 2023, read in part, .Admission and Readmission Assessment, upon admission resident vital signs will be monitored and recorded each shift for 72 hours. Any abnormalities will be reported to physician for recommendation . Res #1 had diagnoses which included high blood pressure, diabetes, and anxiety. An admission nurse note, dated 01/11/24, documented vital signs of blood pressure 144/93, respiratory rate, 28, pulse 103, temperature 101.1, oxygen saturation 96% on room air, and no complaints of pain. Res #1's MAR, dated 01/11/24, contained no documentation for the administration of a fever reducing medication. The nurse notes did not contain documentation the physician was notified related to the abnormal high temperature. The clinical record did not document the temperature was rechecked. The MAR did not document a medication was administered to reduce the temperature. On 02/01/24 at 2:10 p.m., RN #1 reported they did not contact the physician on admission for Res #1's elevated temperature or recheck the temperature. They were asked if the MAR contained anything administered for an elevated temperature. They stated, I don't see an order for Tylenol. They were asked why the physician would not be notified for an elevated temperature. They reported they honestly did not remember why. On 02/02/24 at 10:25 a.m., the corporate RN was asked to review Resident #1's clinical record. They were asked if the clinical record contain a physician's order for Tylenol on admission to the facility. They stated there was no order for a fever reducing drug in the physician orders or in the physician start up orders.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 30875 Based on record review and interview, the facility failed to maintain an accurate clinical record to include the resident's responsibly party contact information for one (#2) of two sampled resident records. The administrator identified 42 residents resided in the facility. Findings: The face sheet, located in the Resident's #2's clinical record, did not identify the responsible party. The face sheet listed a second contact person's name with a phone number, and a third contact person's name without a phone number. On 02/02/24 at 9:46 a.m., the corporate RN identified the DPOA as Res #2's responsible party and identified the third contact person without a phone number on the face sheet as the DPOA. They reported it needed to be updated.