

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375490	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2025
NAME OF PROVIDER OR SUPPLIER Marlow Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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. (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on record review and interview, the facility failed to ensure residents were free from for 2 (#1 and #2) of 2 sampled residents reviewed for abuse. The administrator identified two allegations of abuse in the past 60 days. Findings: An undated policy titled Abuse Policy and Procedure, read in part, We will endeavor to protect our occupants from maltreatment, which means adult abuse, exploitation, neglect, physical abuse, sexual abuse, neglect, and the misappropriation of resident property. Sexual abuse. Includes sexual harassment, sexual coercion, or sexual assault. 1. A care plan for Resident #1, dated 10/08/25, showed the resident had diagnoses which included COPD, diabetes, congestive heart failure, hypertension, and rheumatoid arthritis. A quarterly MDS assessment for Resident #1, dated 11/04/25, showed the resident has a BIMS of 15, which indicated the resident was cognitively intact. An OSDH [Oklahoma State Department of Health] Incident Report Form, dated 11/07/25, showed Resident #1 reported to the administrator CNA #1 had touched the resident's private part. The report showed notification to authorities and suspension of CNA #1 with an investigation initiated. On 11/12/25 at 9:30 a.m., Resident #1 was interviewed in their room and asked if anyone had touched them inappropriately. The resident did not give any details and asked the surveyor to talk to the administrator about the incident. On 11/12/25 at 10:40 a.m., the administrator reported Resident #1 initially went to a nurse and told them they needed to speak with the administrator, but did not tell the nurse what it was about. The administrator reported as soon as Resident #1 told them CNA #1 had touched them inappropriately, CNA #1 was suspended, and the investigation was initiated. The administrator reported in the process of interviewing other residents on 11/07/25, Resident #2 reported CNA #1 had groped them in the shower. The administrator reported Resident #2 stated the incident happened a while ago and the resident had not reported it to anyone. On 11/13/25 at 9:15 a.m., Resident #1 was interviewed in their room with the administrator present. Resident #1 reported the incident with CNA #1 happened in their room. Resident #1 reported CNA #1 had put lotion on their legs after they had their shower, which they did independently without the CNAs assistance. Resident #1 reported CNA #1 came at them and touched them. Resident #1 was asked if CNA #1 touched their private area. Resident #1 stated, Yes. Resident #1 was asked if they had clothes on and the resident reported they were wearing shorts. Resident #1 was asked if they thought CNA #1 could have touched them accidentally when applying lotion. Resident #1 reported no, the lotion had already been applied prior to CNA #1 touching their private area. Resident #1 stated CNA #1, came at me and rubbed me. Resident #1 reported CNA #1 did not reach inside their shorts, but rubbed them on the outside of their shorts. Resident #1 was asked if CNA #1 exposed themselves. Resident #1 reported CNA #1 showed them their breasts. Resident #1 reported they were not afraid of CNA #1, but the incident made them feel uncomfortable and they wanted CNA #1 out of their room. Resident #1 reported CNA #1, went too far and crossed the line. Resident #1 reported CNA #1 left their room when they told them to leave. 2. A care plan for Resident #2, dated 02/16/25, showed the resident had COPD, chronic pain, kidney cancer, and osteoarthritis. A quarterly MDS assessment for Resident #2, dated 08/12/25, showed the resident had a BIMS of 15, which indicated the resident was cognitively intact. On 11/12/25 at 11:18 a.m., Resident #2 was asked if anyone had ever touched them inappropriately. Resident #2 reported they had just talked with the administrator a couple of days previous about an incident with CNA #1 in the shower. Resident #2 reported CNA #1 groped them while assisting them with a shower. Resident #2 reported they did not think of the incident as abuse, but knew it was inappropriate behavior. Resident #2 reported they could not remember exactly when the incident happened, but they did not tell anyone about the incident until the administrator questioned them recently. On 11/12/25 at 2:05 p.m., CNA #1 was interviewed by telephone. CNA #1 reported they had never touched a resident inappropriately or exposed themselves to a resident. CNA #1 reported they did not know why the residents had made the accusations of being touched inappropriately. On 11/13/25 at 9:30 a.m., the ADON reported Resident #1 had not reported abuse of any kind prior to the incident with CNA #1. The ADON reported CNA #1 had worked at the facility a couple of months and there had been no previous allegations of abuse against the CNA.</p>		