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	06/28/2024

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30875 Based on record review and interview, the facility failed to ensure residents were offered the choice to formulate advanced directives for three (#20, 29, and #37) of twelve sampled residents reviewed for advanced directives. The corporate RN consultant reported 41 residents resided in the facility. Findings: The facility policy Advance Directives and Do Not Resuscitate Orders not dated, read in part, The Patient Self-Determination Act of 1990 is a federal law that went into effect on December 1, 1991. The legislation was created to ensure the legal right of each competent adult to make his/her own medical decisions. The act mandates Medicare and Medicaid certified nursing facilities to give residents information about their right to make decisions concerning medical care including the right to accept or refuse treatment and the right to formulate advance directives. 1. Res #20 was admitted to the facility on [DATE]. The resident had diagnoses which included unspecified dementia. Res#20's advanced directive acknowledgement form was not completed. Res #20's electronic medical record documented the resident's code status was full code. 2. Res #29 was admitted to the facility on [DATE]. The resident had diagnoses which included generalized anxiety disorder. Res #29's advanced directive acknowledgement form was not completed. 3. Res #37 admitted to the facility on [DATE]. The resident had diagnoses which included chronic kidney disease. Res #37's advanced directive acknowledgement for was not completed. On 06/24/24 at 3:23 p.m., Corporate RN consultant reported Res #37 did not have an advance directive acknowledgement for this resident. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/24/24 at 3:25 p.m., Corporate RN consultant reported Res #29 did not have an advance directive acknowledgement on file. On 06/24/24 at 3:27 p.m., Corporate RN consultant reported Res#20 did not have an an advance directive acknowledgement on file.

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 06/28/2024
NAME OF PROVIDER OR SUPPLIER Marlow Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 702 South 9th Marlow, OK 73055	

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30875 Based on record review and interview, the facility failed to ensure accurate coding of a MDS assessment for one (#29) of one sampled resident related to a discharge to the hospital after a reportable fall. The corporate RN consultant reported 41 residents resided in the facility. Findings: A quarterly assessment, dated 04/30/24, documented no upper or lower impairment and independent with transfers. A nurse's note, dated 05/28/24, for Res #29, documented, resident fell in bathroom from toilet. Mobile x-ray confirmed left femur femoral neck fracture. Physician notified. Resident transferred to hospital. A State reportable, dated 05/28/24, documented, self transferring and fell x-ray of left hip acute femoral neck fracture. A nurse's note, dated 05/31/24, read Res #29 returned to facility from hospital per facility van. Alert and oriented x2, cheerful and cooperative, dressing to left hip. On 06/28/24 at 10:50 a.m., MDS coordinator confirmed the MDS assessment recorded Res #29 was discharged on [DATE] and returned to the facility on [DATE] from a fall and a fracture. On 06/28/24 at 11:07 a.m., MDS coordinator reviewed MDS assessment, they reported they made an error and entered the wrong date and the resident had discharged on [DATE] and returned to the facility on [DATE] to skilled services.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 41873 Based on record review and interview, the facility failed to refer a resident with a newly evident or possible serious mental illness to the OHCA for a level II PASRR evaluation for one (#23) of two sampled residents reviewed for PASARR. The corporate RN consultant reported 41 residents resided in the facility. Findings: Res #23 had diagnoses which included dementia, anxiety, depression, psychotic disorder, and schizoaffective disorder. A level I PASRR, dated 07/14/22, documented Res #23 had a primary diagnosis dementia with behavioral disturbances. The PASARR documented no evidence or diagnosis of a serious mental illness. A comprehensive assessment, dated 03/19/14, documented Res #23 had moderate cognitive impairment. The assessment documented the resident had active diagnoses to include dementia, anxiety, depression, psychotic disorder, and schizoaffective disorder. Res #23's physician's order, dated 06/01/24, documented the following medications and orders: 01/17/23 Millennium Mental Health Evaluate and treat. 04/22/24 Melatonin 3 for dementia with behavioral disturbance. 06/20/23 Buspirone HCL 10 mg for anxiety. 12/13/23 Lorazepam 0.5 mg for anxiety 0/28/23 Zoloft 50 mg for depression 01/17/23 Trazodone HCL 100 mg for depression. 07/31/23 Risperdal 2 mg for schizoaffective disorder. 12/31/23 Hydroxyzine HCL 25 mg prn for anxiety. There was no documentation the resident had been referred to the OHCA for a level II PASRR evaluation. On 06/26/24 at 10:25 am., Corporate RN consultant reported resident #23's PASARR had not been reevaluated with the diagnoses of anxiety, depression, or schizoaffective disorder. The corporate RN consultant reported these diagnoses were not included on the PASARR dated 07/14/22 and the resident should have been rescreened for need of a level II services.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 41873 Based on observation, record review, and interview, the facility failed to develop and implement a comprehensive person-centered care plan for three (#11, 23 and #37) of twelve sampled residents reviewed for comprehensive care plans. Findings: The corporate RN consultant reported 41 residents reside in the facility. A Care Plans, Comprehensive Person-Centered policy, read in part, A comprehensive, person centered care plan that includes measurable objective's and timetables to meet the resident's physical, psychological, and functional needs is developed and implemented for each resident. 1. Res #11 had diagnoses which included end stage renal failure. A physician's order, dated 02/03/24, documented to obtain Res #11's weight on Monday, Wednesday, and Friday before going to dialysis. A comprehensive assessment, dated 04/23/24, documented Res #11's cognition to be intact and was dependent on staff for activities of daily living. The assessment documented the resident received dialysis services while a resident. A care plan, dated 05/03/24, documented no care area related to dialysis. On 06/27/24 at 3:02 p.m., MDS coordinator reported dialysis services should be included on Res #11's care plan. 2. Res #23 had diagnoses which included dementia, diabetes mellitus, and hypertension. A physician order, dated 01/17/23, documented Admit to Choice Hospice. A comprehensive assessment, dated 03/19/24, documented the Res #23's cognition was moderately impaired. The assessment documented the resident received hospice services. A care plan, dated 11/27/23, documented no care area related to hospice services. On 06/27/24 at 3:02 p.m., MDS coordinator reported hospice services should be included on Res #23's care plan. 30875 4. Res #37 had diagnosis which included anemia, renal insufficiency, and diabetes mellitus. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's orders, dated 05/19/24, documented, suprapubic catheter may use leg band 16 FR/30 CC bulb to urinary drainage bag change as needed for dislodgement sedimentation, catheter care every shift. The comprehensive care plan did not contain any information related to a suprapubic catheter. A physician orders, dated 05/19/24, for Res #37, documented, dialysis every Monday, Wednesday, and Friday. Please send copy of pre dialysis assessment to dialysis appointments. On 06/25/24 at 2:02 p.m., Res #37 sitting in recliner in his room and CNA #1 was asked about Res #37's dialysis. They reported they obtained vital signs and weight, when they leave and when they return back from dialysis. Reported they had a port on the upper chest area. On 06/26/24 at 2:27 p.m., Res #37 returned from dialysis and was eating a sandwich in the dining area. On 06/27/24 at 11:05 a.m., Corporate RN consultant was asked if Res #37 was care planned for a supra pubic catheter and/or dialysis. They reported they had already discussed this with the care plan coordinator to include a plan of care for dialysis and a supra pubic catheter. On 06/26/24 at 2:34 p.m., Corporate RN consultant reported Res #37 did not have a plan of care for dialysis and reported they would expect them to have one. On 06/27/24 at 11:05 a.m., Corporate RN consultant #1 was asked if Res #37 was care planned for a supra pubic catheter and/or dialysis. They reported they had already discussed this with the care plan coordinator to include a plan of care for dialysis and a supra pubic catheter. On 06/27/24 at 3:02 p.m., MDS coordinator reported suprapubic catheter and dialysis would be included on the plan of care. They stated they were completing one for Res #37 right now.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 41873 Based on record review and interview, the facility failed to ensure a resident's care plan was reviewed and revised for one (#15) of 12 residents reviewed for care plans. The RN consultant reported 41 residents resided in the facility. Findings: The facility's Care Plans, Comprehensive Person-Centered policy, read in part A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. Res #15 had diagnoses which included depression, seizure disorder, and psychotic disorder. A care plan, dated 05/18/23, read in part Antidepressant medication use: At risk for side effects . Antipsychotic drug use: At risk for side effects .Seizure disorder: At risk for side effects . The care plan documented the last date revised was 06/13/23 and last reviewed on 08/18/23. Res #15's clinical record documented an inpatient psych hospital admission from 04/03/24 through 05/02/24. A comprehensive assessment, dated 05/09/24, documented cognition was intact and no mood behaviors. The assessment documented antipsychotic, antidepressant, and hypnotic medication use. Res #15's physician orders, dated 06/01/24, documented Seroquel XR 150 mg, Zoloft 100 mg, Trintellix 10 mg, Melatonin 3 mg, Keppra 500 mg, Namenda 10 mg, Rozerem 8 mg, and Vraylar 3 mg. On 06/27/24 at 11:20 a.m., the RN consultant reported care plans had been an issue and the new MDS nurse was working on getting them updated. The RN consultant reported the resident's care plan should have been revised with the last comprehensive assessment.

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 30875 Based on observation, record review, and interview, the facility failed to provide bathing as outlined in their care for one (#6) of one sampled resident reviewed for bathing assistance. The corporate RN reported 41 residents resided in the facility. Findings: Res #6 diagnosis included debility, cardiorespiratory conditions, heart failure and depression. An assessment, dated 06/04/24, for Res #6, documented impairment on both sides and required substantial max dependence for ADL's. On 06/24/24 at 1:53 p.m., Res #6 voiced no complaints, there was a smell of body odor in the room; however, resident reported they received their showers. On 06/27/24 at 3:37 p.m., Corporate RN consultant submitted the shower sheets for resident #6 and reported they had a designated person who did the showers and they may or may not have filled out the ADL book. After they submitted the sheets, they agreed there were still blanks because Res #6 was supposed to be showered on Monday, Wednesday, and Friday and they were not. A shower list, not dated, documented Res #6 showered on Monday, Wednesday, and Friday. An ADL list, dated June 2024, for Res #6, documented, bathing: S-Shower, BB-bed bath, N-not bath day. The sheet documented five days as a S and one day as a R, and 21 days were marked as N out of 27 opportunities for the month of June.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41873 Based on record review and interview, the facility failed to ensure a resident was assessed after dialysis treatments per physician's order for one (#11) of two residents reviewed for dialysis. The RN consultant reported three residents that resided in the facility received dialysis services. Findings: Res #11 had diagnoses which included end stage renal failure. A comprehensive assessment, dated 04/23/24, documented resident #11's cognition was intact. The assessment documented the resident received dialysis services. A care plan, dated 05/03/24, documented no dialysis services. A physician's order dated 06/16/24 documented obtain blood pressure and pulse immediately after returning from dialysis appointment. Res #11's dialysis communication forms dated, 06/17/24, 06/19/24, and 06/21/24 documented no blood pressure and pulse readings after returning from the dialysis appointments. A dialysis communication form for Res #11, dated 06/24/24, documented blood pressure 101/79 and pulse 79. On 06/26/24 at 2:43 p.m., LPN #3 reported Res #11's blood pressure and pulse was documented at the bottom the of dialysis communication form when the resident returned to the facility from dialysis. On 06/28/24 at 10:33 a.m., Corporate RN consultant reported Res #11's blood pressure and pulse was documented after returning to the facility on [DATE]. The Corporate RN consultant reported the Res #11's blood pressure and pulse was not obtained immediately after returning from dialysis as ordered on 06/17/24, 06/19/24, and 06/21/24.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 41873 Based on record review and interview, the facility failed to ensure medication regimen reviews conducted by the pharmacist were acted on for two (#15 and #21) of five residents reviewed for unnecessary meds. The corporate RN consultant reported 41 residents resided in the facility. Findings: The facility's Medication Regimen Reviews policy, dated 05/01/23, read in part The Consultant Pharmacist performs a medication regimen review for every resident in the facility receiving medication .The medication regimen review involves a thorough review of the resident's medical record to prevent, identify, report and resolve medication related problems, medication errors and other irregularities .The attending physician documents in the medical record that the irregularity has been reviewed and what action was taken to address it. Copies of medication regimen review reports, including physician responses, are maintained as part of the permanent record . 1. Res #15 had diagnoses which included depression, seizure disorder, and psychotic disorder. Res #15's physician orders, dated 03/01/24, documented the following medications: hydroxyzine hcl 50 mg 1 daily, Zoloft 100 mg 1 daily, trazodone 100 mg 1 at bedtime, haloperidol 5 mg 1 twice a day, and Haldol Deconoate 100 mg/ml 1 ml intramuscular every month. A pharmacist medication regimen review, dated 03/05/24, documented the pharmacist recommended the following psychotropic medications has/have been ordered and in place routinely for greater than or approaching 12 months without a gradual dose reduction. Please consider, if appropriate, such a reduction of one of these agents: hydroxyzine 50 mg daily, Haldol 5 mg twice daily, Haldol 100 mg intramuscular monthly. The medication regimen review documented no physician or facility response. A comprehensive assessment, dated 05/09/24, documented cognition was intact and no mood behaviors exhibited. The assessment documented antipsychotic, antidepressant, and hypnotic medication use. 2. Res #21 had diagnoses which included anxiety and depression,. (continued on next page)

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

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A pharmacist medication regimen review, dated 03/05/24, documented a pharmacist recommendation, consider a dose reduction of one of the following: venlafaxine ER 75 mg daily, buspirone 5 mg twice daily. The medication regimen review documented no physician response or facility acknowledgement. Res #21's medical record documented an inpatient psych hospital stay 04/03/24 through 05/02/24. A comprehensive assessment, dated 05/07/24, documented cognition was intact and no mood behaviors exhibited. The assessment documented antianxiety, antidepressant, and hypnotic medication use. Res #21's physician orders, dated 06/01/24, documented the following medications: venlafaxine ER 75 mg 1 daily, buspirone 5 mg 1 twice a day, and trazodone 50 mg 1 at bedtime. On 06/27/24 at 2:10 p.m., Corporate RN consultant reported the medication regimen review, dated 03/05/24, for resident #15 had not been acted on by the physician or facility. The Corporate RN consultant reported the medication regimen review, dated 05/07/24, for Res #21 had not been acted on by the facility. The Corporate RN consultant reported the above medication regimen reviews were not found in the residents' medical records.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30875 Based on record review and interview, the facility failed to ensure the medication was necessary to treat a specific condition indicated in the clinical record and failed to ensure an as needed psychotropic medication was limited to 14 days for one (#20) of five residents reviewed for unnecessary medications. The corporate RN consultant reported 41 residents resided in the facility. Findings: The facility's Medication Regimen Reviews policy, dated 05/01/23, read in part The Consultant Pharmacist performs a medication regimen review for every resident in the facility receiving medication .The medication regimen review involves a thorough review of the resident's medical record to prevent, identify, report and resolve medication related problems, medication errors and other irregularities. A physician order, dated May 2024, for Res #20, documented, Lorazepam 1 mg tablet give 1 tablet per peg every 6 hours as needed for anxiety. Res #20's diagnosis included unspecified dementia, depression, unspecified, and essential hypertension. The Res # 20 did not have a diagnosis of anxiety. On 06/28/24 at 9:50 a.m., MDS coordinator was asked if the MDS dated [DATE] included a diagnosis of anxiety. They stated they did not see one on there. They were asked if they would expect the Res #20 to have a diagnosis of anxiety if they received anti-anxiety medication. They stated they would expect them to have that diagnosis. On 06/28/24 at 10:10 a.m., Corporate RN consultant stated Lorazepam was ordered on 03/26/24 and Res #20 had not received any in June 2024, but they knew you could not have a PRN order over 14 days.

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	375490	A. Building B. Wing	06/28/2024

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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 the medication rate less than 5%. A total of 25 opportunities were observed with two errors. The total medication error rate was 8%. The corporate RN consultant reported 41 residents reside in the facility. Findings: A Medication and Treatment Orders, policy, dated 07/2023, read in part, Orders for medications and treatments will be consistent with principles of safe and effective order writing. A medication pass was conducted on 06/27/24 at 9:03 a.m., with ACMA #1. They administered one Clonidine 0.2 mg tablet to Res #35. They were asked if they already checked the blood pressure. They reported it was not required and their blood pressure ran pretty high and they had discontinued the blood pressure. A physician orders, dated June 2024, for Res #35 documented, Clonidine 0.2 mg tablet give one tablet by mouth twice daily hold if BP less than 100/60 and or pulse is less than 60 for Hypertension .Glipizide 5 mg two tabs to equal 10 mg by mouth daily. The pharmacy card read to administer the medication 30 minutes before breakfast and ACMA #1 reported they did not give them the Glipizide 30 minutes before breakfast. On 06/27/24 at 10:20 a.m., Corporate RN consultant was asked about Res #35's blood pressure. They reported they should have checked the blood pressure and the order should have been ordered separately, so there would be an order to record the blood pressure. They were asked about the discrepancy between the pharmacy card and physician's orders. They reported the original order documented to administer the Glipizide 30 minutes before breakfast and during the transcription of the order that part was left off.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely, quality laboratory services/tests to meet the needs of residents. 41873 Based on record review and interview, the facility failed to ensure blood work was obtained per physician orders for two (#7 and #11) of five residents reviewed for unnecessary meds. The corporate RN consultant reported 41 residents resided in the facility. Findings: The facility's Lab and Diagnostic Test Results-Clinical Protocol policy, read in part The physician will identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs .The staff will process test requisitions and arrange for tests . 1. Res #7 had diagnoses which included diabetes mellitus, anemia, and non-traumatic brain dysfunction. Res #7's physician orders, dated 06/01/24, read in part Order date 08/17/23: HGBA1C every 3 months in August, November, February, May. CBC, CMP every 6 months in August and February . A comprehensive assessment, dated 06/03/24 documented Res #7's cognition was not scored due to inability to verbalize. The assessment documented the resident was dependent on staff for activities of daily living. Res #7's clinical record documented no labwork results for February 2024. On 06/27/24 at 9:25 a.m., Corporate RN consultant reported resident #7's lab work (CBC, CMP, and HGBA1C) ordered for February 2024 had not been obtained. The Corporate RN consultant reported the facility had failed to order the lab work. 2. Res # 11 had diagnoses which included end stage renal failure, diabetes mellitus, anemia and hypothyroidism. Res #11's physician orders, dated 06/01/24, read in part Order date 02/03/23: TSH lab work yearly in April. CMP and CBC lab work every 6 months in April and October . A comprehensive assessment, dated 04/23/24, documented resident #11's cognition was intact and received dialysis services. The assessment documented dependent on staff for most activities of daily living. Res #11's clinical record documented no labwork results for April 2024. On 06/26/24 at 2:16 p.m., Corporate RN consultant reported resident #11's lab work (CBC, CMP, and TSH) ordered for April 2024 had not been obtained. The Corporate RN consultant reported the facility had failed to order the lab work.

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 06/28/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 41873 Based on observation, record review, and interview, the facility failed to ensure staff was alerted to implement enhanced barrier precautions for three (#7, 20, and #37) of five sampled residents reviewed enhanced barrier precautions. The Corporate RN consultant reported 41 residents resided in the facility. Findings: 1. Res #7 had diagnoses which included non-traumatic brain dysfunction. Res #7's physician order, dated 10/19/23, read in part Bolus feed - Jevity 1.2 give 237 ml via peg tube .Feed 6 times a day to gravity for meal replacement . A comprehensive assessment, dated 06/03/24 documented Res #7's cognition was not scored due to inability to verbalize. The assessment documented the Res #7 was dependent on staff for activities of daily living and received tube feeding services. On 06/24/24 at 2:19 p.m., Res #7 was observed in bed, peg tube in place, no PPE supplies or enhanced barrier precautions signage in place. On 06/24/24 at 10:06 a.m., Corporate RN reported there was no EBP in the facility, but there probably should be enhanced barrier precautions in place. On 06/26/24 at 11:59 a.m., LPN# 3 was observed using full PPE to perform Res #7's tube feeding. The LPN #3 reported the nurses received training on 06/25/24 related to enhanced barrier precautions and had just started using full PPE during tube feedings and care. The LPN #3 reported no enhanced barrier precautions had been in place until 06/25/24. 30875 2. An admission assessment, for Res #20, dated 03/29/24, documented no upper or lower impairment with moderate cognitive impairment. A care plan, dated 03/29/24, for Res #20, documented, nutritional intake: peg tube for only source of nutrition and fluids, IS NPO. Maintain in an upright position for a specified time after each feedings. A physician order, dated June 2024, documented, Jevity 1.5 cal give 8 ounces via peg five times daily to check residual every five hours before feeding. Flush peg with 30 ml water prior to and after administration of meds. Give 120 ml free water every 4 hours. NPO (nothing by mouth). On 06/24/24 at 10:06 a.m., Corporate RN reported there was no EBP in the facility, but there probably should be enhanced barrier precautions in place. (continued on next page)

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 06/28/2024
NAME OF PROVIDER OR SUPPLIER Marlow Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 702 South 9th Marlow, OK 73055	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/25/24 at 09:28 a.m., Res #20 has Jevity 1.5 at bedside with syringe dated 06/25/24. No enhanced barrier precautions sign was posted on the door. On 06/26/24 at 10:48 a.m., EBP sign was posted on Res #20's door today and a container with PPE was located outside of the resident's door on the second day of survey. 3. Resident #37 had diagnosis which included anemia, renal insufficiency, and diabetes mellitus. An admission assessment, dated 05/30/24, documented, Res #37 with a moderate cognitive impairment and an indwelling cath in place. A care plan, dated 06/05/24, documented an indwelling catheter. A physician's orders, dated 05/19/24, suprapubic catheter may use leg band 16 FR/30 CC bulb to urinary drainage bag change as needed for dislodgement sedimentation. Catheter care every shift. On 06/25/24 at 09:19 a.m., indwelling catheter to gravity. The door was not marked for enhanced barrier precautions. On 06/25/24 at 01:45 p.m., CMA #2 obtained BP from Resident #19 and then entered Resident #37's room to take his blood pressure with the same blood pressure cuff. They were asked if they sanitized the BP cuff they stated, No,they did not, but they reported they had purple wipes in the medication cart. They pulled the wipes out and sanitized the cuff. On 06/25/24 at 02:02 p.m., Resident #37 sitting in recliner in his room and CNA #1 washed hands and donned gloves and emptied Res 37's catheter. There was 180 milliliters of yellow colored urine measured in the urinal. They removed the gloves and sanitized hands. They were asked if they had training for EBP. They reported they were not familiar with that and had not received training to wear a gown when emptying the indwelling catheter. On 06/26/24 at 02:23 p.m., CNA #1 was asked when the PPE was placed outside of Res #37's door. They reported this morning. They were asked if they received in-service related to EBP. They reported they were in-serviced yesterday.

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	06/28/2024

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

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41873 Based on record review and interview, the facility failed to ensure residents were offered the pneumonia vaccination according to policy for three (#4, 20, and #30) of five sampled residents reviewed for immunizations. The corporate RN consultant reported 41 residents resided in the facility. Findings: The facility's Pneumococcal Vaccine policy, dated 08/01/23, read in part: Prior to or upon admission, residents will be assess for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within thirty days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. Assessments of pneumococcal vaccination status will be conducted within five working days of the resident's admission if not conducted prior to admission. Residents/representative have the right to refuse vaccination. If refused, appropriate entries will be documented in each resident's medical record indicating the date of the refusal of the pneumococcal vaccination. For residents who receive the vaccines, the date of the vaccination, lot number, expiration date, person administering, and the site of vaccination will be documented in the resident's medical record. 1. Res #4 was admitted to the facility on [DATE]. Res #4 had diagnoses which included hemiplegia and diabetes mellitus. The resident's medical record documented no proof the resident was offered vaccinations and screened for vaccination status. 2. Res #20 was admitted to the facility on [DATE]. Res #20 had diagnoses which included coronary artery disease and dementia. The resident's medical record documented no proof the resident was offered vaccinations and screened for vaccination status. A Covid 19 Series form, dated 06/21/24, read in part, I am declining the current CDC recommended Covid 19 Vaccine at this time .I am opting to take the pneumonia vaccine if I am eligible . 3. Res #30 was admitted to the facility on [DATE]. (continued on next page)

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

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Res #30 had diagnoses which included atrial fibrillation, dementia, and diabetes mellitus. A Covid 19 Series form, dated 06/24/24, read in part, I am declining the current CDC recommended Covid 19 Vaccine at this time .I am declining to take the pneumonia vaccine currently . The resident's medical record documented no proof the resident was offered vaccinations and screened for vaccination status. On 06/28/24 at 2:50 p.m., Corporate RN consultant reported there was no documentation that residents #4, 20, and #30 were assessed for vaccination status within 5 days of admission. The corporate RN reported the business office was responsible to screen residents during admission and obtain the vaccine consent or declination. The corporate RN consultant reported new staff had not been obtaining vaccine consent or declination and had not been documenting resident vaccination status. The Corporate RN consultant reported documentation of resident vaccination status was not being tracked.