Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265663	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/21/2024
NAME OF PROVIDER OR SUPPLIER Fulton Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 Bluff Street Fulton, MO 65251	

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43010 Based on interview and record review, facility staff failed to complete neurological checks and fall follow up documentation for three (Resident #1, #2, & #3) of three residents who had a fall and failed to complete weekly skin assessments for two residents (Resident #4 and #5). The facility census was 41. 1. Review of the facility's Fall Champion Program, undated, showed the post fall follow up period is 72 hours which includes assessment and document of the resident's condition in healthcare tracking program Progress Notes and neurological checks. 2. Review of Resident # 1's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 11/23/23, showed staff assessed the resident as: -Cognitively intact; -No falls since admission or prior assessment. Review of the resident's care plan, dated 11/27/23, showed staff assessed the resident at risk for falls due to history of falls. Staff are directed to provide proper, well-maintained footwear with nonskid soles, adjust bed to lowest level, and encourage resident to pull call light for help when it's needed. Review of the event report, dated 1/4/24, showed staff documented the resident found on the floor because he/she slipped out of his/her wheelchair. Review of the resident's medical record did not contain documentation staff completed the 72 hours follow up fall documentation for the 1/4/24 fall. 3. Review of Resident # 2's Annual MDS, dated [DATE], showed the staff assessed the resident as: -Cognitively intact; -No falls since admission or prior assessment. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's care plan, dated 11/27/23, showed staff assessed the resident had a history of falls related to antidepressant medication use, incontinence episodes, and a history of falling. Staff are directed to assist for all transfers because the resident is non-ambulatory, keep bed in lowest position with brakes locked, keep call light in reach at all times, keep personal items and frequently used items within reach, and provide proper, well-maintained footwear. Review of the event report, dated 1/21/24, showed the resident had an unwitnessed fall and sent to the emergency room . Review of the resident's medical record did not contain documentation staff completed the 72 hours follow up fall documentation for the 01/21/24 fall. 4. Review of Resident # 3's Annual MDS, dated [DATE], showed the staff assessed the resident as: -Cognitively intact; -One fall without injury since admission or prior assessment; -One fall with injury since admission or prior assessment. Review of the resident's care plan, dated 11/27/23, showed the resident had a history of falling related to weakness. Staff are directed to keep call light in reach at all times, keep personal items and frequently used items within reach, provide proper well-maintained footwear, and provide toileting assistance as needed. Review of the event report, dated 1/7/24, showed the resident had an unwitnessed fall between the wall and bed. Review of the resident's medical record did not contain documentation staff completed the 72 hours follow up fall documentation for the 1/7/24 fall. Review of the event report, dated 1/9/24, showed staff documented the resident found on the floor in his/her room. Review of the resident's medical record did not contain documentation staff completed the 72 hours follow up fall documentation for the 1/9/24 fall. 5. During an interview on 2/8/24 at 2:48 P.M., the administrator said nurses are responsible for completing neurological checks and follow up charting for residents who fall. He/She said they've not had a Director of Nursing (DON) and one of their corporate nurses is there to help. He/She does not know why they are not being done because the nurses know they should be. During an interview on 2/8/24 at 2:55 P.M., Licensed Practical Nurse (LPN) A said he/she knows neurological checks and follow up fall charting should be done, but has not completed them. He/She said he/she does not know where the sheets are kept and when he/she asked where the sheets were, he/she did not get a straight answer. He/She said neurological and follow up charting should be completed for 72 hours and does not know who is responsible for making sure they are completed. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/8/24 at 3:36 P.M., Registered Nurse (RN) C said nurses are responsible for completing neurological and follow up fall charting for 72 hours. He/She said he/she does not know who is responsible at this time to make sure it's completed. During an interview on 2/8/24 at 3:59 P.M., RN F said nurses should be completing neurological and follow up charting for 72 hours. He/She said he/she would be responsible for making sure they're completed but does not know why they are not being done. During an interview on 2/8/24 at 8:27 P.M., LPN D said nurses are responsible for completing neurological and follow up charting. He/She said charting should be done for 72 hours and he/she does not know why they are not being completed. He/She said the DON would be responsible for making sure staff completed these tasks but does not know who is responsible at this time. 6. Review of the facility's wound care prevention strategies, undated, showed staff were directed to perform on-going skin assessment with weekly documentation of status. 7. Review of Resident #4's Quarterly MDS, dated [DATE], showed staff assessed the resident as moderately cognitively impaired. Review of the resident's care plan, dated 3/14/22, showed staff assessed the resident with a history of scratching his/her skin. Review of the resident's weekly skin assessments form, dated 8/1/23 to 2/21/24, showed staff documented they completed a weekly skin assessment for the week of 1/17/24. The resident's medical record did not contain completed skin assessments for any other weeks. 8. Review of Resident #5's Quarterly MDS, dated [DATE], showed staff assessed the resident as severely cognitively impaired. Review of the resident's care plan, dated 6/7/23, did not contain pressure ulcer or skin care interventions. Review of the resident's weekly skin assessments form, dated 8/1/23 to 2/21/24, showed staff documented they completed a weekly skin assessment for the weeks of 8/31/23 and 10/28/23. The resident's medical record did not contain completed skin assessments for any other weeks. 9. During an interview on 2/21/24 at 1:07 P.M,, the Director of Nursing (DON) said his/her expectation is that skin assessments are completed weekly by the nursing staff. He/She said he/she is new and is not sure why they have not been completed in the past. During an interview on 2/21/24 at 1:45 P.M., LPN G said he/she the nurses are in charge of weekly skin assessments. He/She said he/she is not sure why they are not getting done besides sometimes the nurses are just too busy. During an interview on 2/21/24 at 1:48 P.M., the administrator said there is a weekly skin assessment schedule at the nurses station that says which days residents are supposed to have their skin assessments completed. He/She said he/she does not know why they are not completed because he/she thought they were being done. (continued on next page)

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