

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 05/14/2025
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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>Based on interview and record review, facility staff failed to contact one resident's (Resident #3's) responsible party after the resident had a change in condition. The facility census 61.</p> <p>1. Review of the facility's Notification of Physician policy, undated, showed staff are directed to immediately inform the resident, consult with the resident's physician, and if known, notify the resident's legal representative or interested family member when there is a significant change in resident's physical, mental, or psychosocial status or a decision to transfer or discharge the resident from the facility.</p> <p>2. Review of Resident #3's Minimum Data Set (MDS), a federally mandated assessment tool, dated 1/22/25, showed staff assessed the resident as follows:</p> <p>-Severe cognitive Impairment;</p> <p>-Diagnoses of dementia with agitation, Senile degeneration of brain, Schizoaffective disorder bipolar type, Vascular dementia with anxiety, and personal history of traumatic brain injury.</p> <p>Review of the resident's care plan, dated 2/3/25, showed staff assessed the resident exhibits significant behaviors towards himself/herself and others. Staff are directed to keep the resident's family and hospice informed of any changes in condition.</p> <p>Review of the resident's medical record showed the resident has an active Durable Power of Attorney (DPOA).</p> <p>Review of the nurses's notes, dated 1/30/25 at 3:10 P.M., showed Licensed Practical Nurse (LPN) B documented the physician ordered a psychiatric evaluation at a Psychiatric Center for agitation and physical behaviors toward other residents. Resident is being monitored one on one, continues to pace up and down the hallway, rocking back and forth. Behaviors change in a moments notice.</p> <p>Review of the nurse's notes, dated 1/31/25 at 5:50 A.M., showed the Social Service Director (SSD) documented the resident's family called this morning to check on resident, states he/she was not informed the resident went out. Staff talked to family and let them know the resident was sent to the hospital yesterday afternoon.</p> <p>(continued on next page)</p>

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
---	-------	-----------

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 05/14/2025
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)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/14/25 at 10:34 A.M., the family member said he/she was not notified of the resident being transferred to the hospital on 1/30/25. He/She said he/she spoke with SSD and found out the resident had been sent to the hospital. He/She said he/she was the active DPOA.</p> <p>During an interview on 5/14/25 at 11:30 A.M., the SSD said when a resident is transferred to the hospital the nurse should notify the family and document it in the system. He/She said he/she is not sure who's responsibility it is for making sure this is completed.</p> <p>During an interview on 5/14/25 at 12:23 P.M., the Director of Nursing (DON) said nurses are expected to notify family when a resident is transferred to the hospital. He/She the nurses are expected to document this in the system in the progress notes. He/She said he/she is responsible for making sure this is completed.</p> <p>During an interview on 5/14/25 at 12:50 P.M., the administrator said when a resident is transferred to the hospital it is the nurses responsibility to notify the family. He/She said the DON is responsible for making sure this is completed.</p> <p>During an interview on 5/14/25 at 2:37 P.M., LPN B said he/she was sure he/she notified the family of the residents transfer to the hospital but must have forgotten to chart it in the system. He/She said typically a progress note is made and he/she must have forgotten to add it. He/She said the DON would be responsible for making sure this is completed.</p> <p>MO00253661</p>		

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 05/14/2025
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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on interview and record review, facility staff failed to keep Resident #1 free from physical abuse when floor technician E aggressively pulled the residents wheelchair which resulted in the resident falling out of the wheelchair and on to the ground. The facility census was 58.</p> <p>The administrator was notified on 4/30/25 of past Non- Compliance, which occurred on 4/22/25, when staff reported the allegation. Staff immediately suspended floor technician E, assessed the resident for physical and psychological harm, conducted an investigation, in-serviced staff on abuse and neglect, and terminated the employee on 4/30/25.</p> <p>1. Review of the abuse, neglect, exploitation, and misappropriation of property fact sheet, dated 2017, showed abuse is the deliberate inflection of injury, unreasonable confinement, intimidation, or punishment, which results in physical harm, pain, or mental anguish. This includes verbal, sexual, physical, or mental abuse, as well as abuse enabled through the use of technology. Examples include scolding, ignoring, ridiculing, or cursing a resident and rough handling during care giving or moving a resident.</p> <p>2. Review of the facility's investigation, dated 4/22/25, showed Certified Nurses Aide (CNA) F notified notified the administrator floor technician E roughly moved Resident #1's wheelchair, causing the resident to fall to the ground. The floor technician was immediately suspended pending the investigation and terminated on 4/30/25. The resident was assessed without injury and all necessary parties were notified.</p> <p>3. Review of the Resident #1's Minimum Data Set, a federal mandated assessment tool, dated 3/12/25, showed staff assessed the resident as follows:</p> <ul style="list-style-type: none"> -Cognitively intact; -Impairment to both lower extremities; -Utilized a manual wheel chair. <p>During an interview on 4/30/25 at 10:28 A.M., the resident said CNA A took him/her out and floor technician E started yelling at him/her and wouldn't let him/her have a cigarette. He/She said floor technician E grabbed his/her wheelchair and moved it roughly causing him/her to fall to the ground. He/She said CNA A and a house keeper helped him/her back to his/her wheelchair. He/She said it hurt and made him/her feel bad and not want to go outside anymore.</p> <p>During an interview on 4/30/25 at 10:43 A.M., CNA D said he/she witnessed the floor technician E yell and refused to allow the resident to smoke because the resident was cursing at the staff. He/She said floor technician told the resident he/she was going to take him/her back inside because of his/her behaviors. He/She said floor technician grabbed the resident's wheelchair he/she was sitting up in and roughly moved it backwards, causing the resident to fall to the ground. He/She said floor technician E did not help the resident up.</p> <p>(continued on next page)</p>		

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 05/14/2025
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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/30/25 at 11:02 A.M., Dietary Manager (DM) said he/she was in his/her office when a dietary staff member told him/her, he/she may want to go outside they think a manager is needed. He/She said he/she went outside to find floor technician E yelling at the resident, while the resident was on the ground in front of his/her wheelchair.</p> <p>During an interview on 4/30/25 at 11:15 A.M., the housekeeper F said he/she and CNA A helped the resident back into his/her wheelchair with a gait belt.</p> <p>During an interview on 4/30/25 at 11:17 A.M., CNA A said he/she took the resident out to smoke because no one had come to get him/her. He/She said he/she pushed the resident up to the table and went to go back inside when he/she heard the resident and floor technician E yelling at each other. He/She said the resident and floor technician were cursing at each other and floor technician forcefully grabbed the resident's wheelchair causing the resident to fall to the ground. He/She and the housekeeper assisted the resident back to his/her wheelchair, made sure he/she was safe, and went to report the incident to the administrator.</p> <p>During an interview on 4/30/25 at 11:28 A.M., the administrator said he/she was notified by the DM and CNA A, floor technician E had been yelling. He/She said floor technician was immediately pulled from the floor and suspended pending their investigation. He/She said the resident was assessed without injury, all necessary parties were contacted, and staff were inserviced on abuse and neglect and resident rights on 4/25/25. He/She said the floor technician was terminated on 4/30/25.</p> <p>During an interview on 5/6/25 at 2:00 P.M., floor technician E said he/she went out with the resident's to smoke. He/She said the resident came outside cursing at him/her and calling him/her a bitch. He/She said he/she told the resident he/she couldn't behave that way and was going to take the resident back inside due to his/her behaviors. He/She said the resident then threw himself/herself to the ground when he/she tried to wheel him/her back inside. He/She said he/she was suspended. He/She said the resident is always acting crazy and cursing people out.</p> <p>MO00253114</p>		