

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 12/31/2025
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</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

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on observation, interview and record review, facility staff failed to maintain an infection prevention and control program to provide a safe and sanitary environment to help prevent the potential spread of Covid-19 (an acute respiratory illness in humans caused by the coronavirus, SARS-CoV-2) and other infections, when staff failed to follow acceptable infection control practices for Covid-19. The facility failed to separate five residents (Resident #1, #3, #7, #10 and #12) who tested positive for COVID-19 from five residents (Resident #2, #4, #8, #9, and #11) who had tested negative for COVID-19, which placed the Covid-19 negative residents at an increased risk of contracting COVID-19 due to prolonged exposure. The facility census was 68. 1. Review of the facility's Outbreak Management: SARS-COV-2 Long Term Facilities policy, revised on 5/15/23, showed staff are directed as follows: -Place a patient with suspected or confirmed SARS-COV-2 infection in a single room. The door should be kept closed (if safe to do so). Ideally, the patient should have a dedicated bathroom;-If cohorting, only patients with the same respiratory pathogen should be housed in the same room;-If limited single rooms are available, or if numerous residents are simultaneously identified to have known SARS-COV-2 exposures or symptoms concerning for COVID-19, residents should remain in their current location;-Facilities could consider designating entire units within the facility, with dedicated HCP (healthcare personnel) are assigned to care only for these patients during their shifts. Dedicated units and/or HCP might not be feasible due to staffing crisis or a small number of infections;-Limit transport and movement of patients outside the required medically essential purposes.2. Review of Resident #1's COVID test results form, dated 12/21/25 and 12/29/25, showed staff documented the resident with a positive result. Review of Resident #2's COVID test results form, dated 12/29/25, showed a negative result.Observation on 12/30/25 at 11:00 A.M. showed Resident #1 and Resident #2 in the same room and did not wear masks. During an interview on 12/30/25 at 3:12 P.M., Resident #2's durable power of attorney (DPOA) stated he/she was made aware by staff there were residents in the facility who tested positive for Covid -19. He/She stated he/she would want Resident #2 to be kept in his/her room and not exposed to others, including at mealtimes. 3. Review of Resident #3's COVID test results form, dated 12/22/25 and 12/29/25, showed staff documented the resident with a positive result.Review of Resident #4's COVID test results form, dated 12/29/25, showed staff documented the resident with a negative result.During an interview on 12/30/25 at 3:50 P.M., Resident #4 said he/she would not want a room with a sick resident but was not asked if he/she would want to move. 4. Review of Resident #7's COVID test results form, dated 12/22/25 and 12/29/25, showed staff documented the resident with a positive result.Review of Resident #8's COVID test results form, dated 12/29/25, showed staff documented the resident with a negative result.Observation on 12/30/25 at 11:00 A.M. showed Resident #3 and Resident #4 in same room and did not wear masks.Observation on 12/30/25 at 01:50 P.M. showed Resident #7 who tested positive for COVID without a facemask sitting in the hall in a wheelchair within close proximity of staff and various residents walking in the hall. Certified Medication Technician (CMT) D assisted Resident #7 to the 300 hall dining room.During an interview on 12/30/25 at 3:55 P.M., Resident #8 said he/she does not want to be in a room with a sick resident, however no one asked if he/she wanted to mover rooms. 5. Review of Resident #9's COVID test results form, dated 12/20/25 and 12/29/25, showed staff documented the resident with a positive result.Review of Resident #10's COVID test results form, dated 12/29/25, showed staff documented the resident with a negative result.Observation on 12/30/25 at 11:35 A.M. showed Resident #9 and Resident #10 in the same room and did not wear masks.Observation on 12/30/25 at 1:25 P.M. and 4:05 P.M., showed Resident #9 out of his/her room. 6. Review of Resident #11's COVID test results form, dated 12/22/25, showed staff documented the resident tested positive.Review of Resident #12's COVID test results form, dated 12/29/25, showed a negative result. During an interview on 12/30/25 at 2:00 P.M., Resident #11 stated he/she would prefer to move rooms if roommate was sick with Covid. His/Her roommate tested positive for COVID-19 on 12/22/25. 7. During an Interview on 12/30/25 at 12:32 P.M., Certified Nurse Assistant (CNA) C stated there were seven Covid positive residents in the 300 Dining Hall out of 13 total residents.During an interview on 12/30/25 at 12:15 P.M., the Director of Nursing (DON) said they follow the policy regarding resident placement during a COVID-19 outbreak, but some residents refuse to be moved and there are not always rooms available. They have relocated some residents. Families were notified that the facility has residents testing positive for COVID-19.During an interview on 12/30/25 at 10:20 A.M., CMT D said he/she did not know which residents had tested positive for COVID-19 but was aware some were positive. He/She said he/she had not been told during shift change</p>		