STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265663	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fulton Nursing & Rehab	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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility staff failed to address and update care plans to address behaviors for three resident (Resident #1, #2 and #3) of three sampled residents and failed to update care plans at least quarterly in conjunction with the required Minimum Data Set (MDS) a federally mandated assessment instrument), to provide interventions to meet individual needs for two residents (Resident #2 and #3) out of three sampled residents. The facility census was 68.1. Review of the facility's policy, Care Plan Comprehensive, undated, showed:-An individualized comprehensive care plan that includes measurable goals and time frames will be developed to meet the resident's highest practicable physical, mental, and psychosocial well-being;-Assessment of each resident is ongoing process and the care plan will be revised as changes occur in the resident's condition;-Applying current standards of practice in the care planning processes;-The interdisciplinary care plan team is responsible for the periodic review and updating of care plan when a significant change in the resident's condition has occurred or when changes occur that impact the resident's care (i.e., change in diet, discontinuation of therapy, changes in care areas that do not require a significant change assessment).2. Review of Resident #1's quarterly MDS, dated [DATE], showed staff assessed the resident as severely cognitively impaired and did not exhibit behaviors of physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) during the seven day look back period.Review of the resident's care plan, dated 11/14/25, showed the care plan did not contain direction for the resident's aggressive behaviors towards residents or interventions in place after three altercations with other residents on 12/07/25, 12/21/25 or 12/22/25. Review of the resident's progress notes, dated 12/07/25, showed staff documented the resident threatened to stab another resident with a knife during an evening meal. Review of the resident's progress notes, dated 12/21/25, showed staff documented the resident hit another resident in face with closed fist unprovoked when exiting the dining room. Review of the resident's progress notes, dated 12/22/24, showed staff documented the resident slapped another resident in the mouth. 3. Review of Resident #2's quarterly MDS, dated [DATE], showed staff assessed the resident as severely cognitively impaired and did not exhibit behaviors of physical behavioral symptoms directed toward others during the seven day look back period.Review of the resident's care plan, dated 08/28/25, showed it did not contain direction for staff regarding aggressive behaviors towards residents or interventions in place after an altercation with another resident on 12/06/25. The care plan was not updated on a quarterly basis.Review of the resident's progress notes, dated 12/06/2025, showed staff documented the resident kicked another resident in the knee for being in his/her chair in the dining room.4. Review of Resident #3's annual MDS, dated [DATE], showed staff assessed the resident as severely cognitively impaired and did not exhibit behaviors of physical behavioral symptoms directed toward others during the seven day look back period.Review of the resident's care (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	plan, dated 08/17/25, showed the resident had behaviors of attempting to hit peers and staff, rummaging, making [NAME] sexual comments, throwing insults upon other, or verbal/vocal symptoms like shouting and making disruptive sounds and refusal of care. The care plan did not contain a new intervention for an altercation on 12/07/25 with another resident. Review of the resident's progress notes, dated 12/07/2025, showed staff documented the resident cursing and calling names. Staff documented the resident then had an altercation with another resident on the 200 hall, when he/she was yelling and cursing at the other resident. 5. During an interview on 01/14/26 at 12:42 P.M. Licensed Practical Nurse (LPN) A said he/she would expect to see a new intervention after each behavioral incident. He/She said he/she did not know if the care plans were updated for the resident's after each altercation. During an interview on 01/14/26 at 12:57 P.M., the DON said he/she would expect a new intervention after each incident and documented in the care plan. He/She said the MDS Coordinator was responsible to update the care plan. He/She said he/she was responsible to verify events and interventions were in place, but he/she said he/she was overwhelmed with other task.During an interview on 01/14/26 at 1:58 P.M., the MDS Coordinator said care plans are updated quarterly, annually and after a significant change. He/She said there should be updated with new interventions after aggressive behaviors. He/She said he/she was the only person who worked on revising or updating the care plans, so when he/she was out of the building, no one was working on the resident care plans. He/She said he/she was out sick for an extended period, and he/she was trying to catch up on his/her care plan responsibilities, in addition to other responsibilities in the facility. #2698585