

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265760	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/12/2024
NAME OF PROVIDER OR SUPPLIER  Fulton Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  520 Manor Drive 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 27152</p> <p>Based on interview and record review, facility staff failed to ensure one resident (Resident #1) remained free from physical abuse when Resident #2 who had a history of physical aggression grabbed Resident #1's arm. The facility census was 39.</p> <p>1. Review of the facility's Abuse, Neglect, and Exploitation Policy, dated 1/31/24, showed abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish which can include staff to resident abuse and certain resident to resident altercations. Review showed physical abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking.</p> <p>2. Review of Resident #1's Minimum Data Set (MDS), a federally mandated assessment tool used to plan care, dated 9/08/24, showed staff assessed the resident with cognitive impairment.</p> <p>Review of the resident's plan of care, updated 12/12/24, showed staff were directed to notify the provider if the resident poses a threat to injure self or others; and to monitor for cognitive, emotional, or environmental factors that may contribute to violent behaviors.</p> <p>Review of the resident's nurse's notes, dated 12/10/24 at 11:06 P.M., showed Licensed Practical Nurse (LPN) A documented a resident informed him/her of a resident altercation between Resident #1 and Resident #2.</p> <p>3. Review of Resident #2's MDS, dated [DATE], showed staff assessed the resident as cognitively intact.</p> <p>Review of the resident's plan of care, updated 12/12/24, showed staff were directed as follows:</p> <ul style="list-style-type: none"> <li>-Reduce unnecessary external stimuli;</li> <li>-Monitor interactions with others;</li> <li>-Resident is at risk for harm: self-directed or other-directed;</li> <li>-Encourage resident to verbalize cause for aggression;</li> </ul> <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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-If resident poses a potential threat to injure self or others, notify provider;</p> <p>-Monitor for cognitive, emotional or environmental factors that may contribute to violent behaviors;</p> <p>-Monitor for signs and symptoms of agitation;</p> <p>-Resident is/has potential to be physically aggressive related to anger, dementia, and poor impulse control;</p> <p>-Analyze times of day, places, circumstances, triggers, and what de-escalates behavior, and document;</p> <p>-12/12/24- Psychiatric/Psychogeriatric consult as indicated;</p> <p>-12/12/24- When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk away calmly, and approach later.</p> <p>Review of the resident's nurse's notes, dated 12/07/24 at 10:00 A.M., showed staff documented the resident an incident of aggressive behavior towards another resident.</p> <p>Review of the resident's nurse's notes, dated 12/07/24, at 6:47 P.M., showed staff documented the resident returned from the hospital, following an incident with another resident. Staff documented staff will place the resident in a room by himself/herself and will watch the resident 24 hours.</p> <p>Review of the resident's nurse's notes, dated 12/09/24, at 5:04 P.M., showed staff documented staff were monitoring the resident one on one due to behaviors. Staff documented the resident was, reaching out for something but unsure for what.</p> <p>Review of the resident's nurse's notes, dated 12/10/24, showed Licensed Practical Nurse (LPN) A documented, while passing medications, a resident notified him/her of an altercation between Resident #1 and Resident #2 at approximately 7:37 P.M. Two residents reported they saw what happened.</p> <p>Review at of the facility surveillance video, at 11:45 A.M. on 12/12/24, showed Resident #2 by the nurse's station in his/her wheelchair. Review showed Resident #1 in his/her wheelchair. Review showed at 7:41 P.M. , Resident #1 propelled himself/herself in between the nurse's station and Resident #2. Resident #2 reached his/her right hand over and grabbed Resident #2's arm. Review showed both residents raise their left arms towards each other with no additional contact. Review showed an unidentified resident propelled himself/herself over to the residents to attempt to have Resident #2 release Resident #1's wheelchair. Review did not show staff in the area of the nurse's station at the time of the incident.</p> <p>(continued on next page)</p>

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<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 12/12/24, at 11:50 A.M., the administrator said she directed staff to monitor Resident #2 one on one after the resident returned from the hospital on 12/07/24, following a physical altercation with the resident's roommate. He/She said LPN A told her LPN A left the resident unattended to pass medications, and did not notify other staff to take over monitoring the resident. The administrator said staff documented the information regarding the need for staff to monitor the resident one on one in the nurse's notes after the resident returned from the hospital on 12/07/24. She said the charge nurse on each shift is responsible for verbally instructing the oncoming shift to monitor the resident one on one.</p> <p>During an interview on 12/13/24 at 2:44 P.M., LPN A said he/she did not witness the incident between Resident #1 and Resident #2. He/She said at approximately 7:30 P.M., while he/she was administering medications, a resident notified him/her Resident #2 grabbed Resident #1 by the arm. He/She said staff did not direct him/her to monitor Resident #2 one on one. He/She said staff directed him/her to monitor Resident #2 with, a little bit of both one on one and 15 minute checks, and to keep Resident #2 away from other residents. He/She said staff positioned Resident #2 by the nurse's station due to the hallway having less traffic. LPN A said Resident #1 propelled himself/herself, halfway down the East hall, before LPN A reached Resident #2.</p> <p>During an interview on 12/18/24 at 8:00 A.M., Certified Nurse Aide (CNA) B said he/she did not witness the incident between Resident #1 and Resident #2. He/She said staff directed him/her to monitor Resident #2 for behaviors, including attempting to get up out of his/her wheelchair unassisted. He/She said he/she did not know staff were supposed to be monitoring the resident one on one or every fifteen minutes.</p> <p>During an interview on 12/18/24 at 4:01 P.M., CNA C said, on the evening of 12/10/24, the off-going charge nurse notified the incoming shift to monitor Resident #2 one on one. He/She said the off-going charge nurse notified LPN A he/she was responsible for monitoring the resident one on one.</p> <p>MO00246416</p>		