| 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 04/27/2026 |
|---|---|---|---|
| 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) |
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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>Based on interviews and record review, facility staff failed to ensure one resident (Resident #1) remained free physical abuse, when Certified Nursing Assistant (CNA) B witnessed CNA A tie a sheet around the resident's upper body to restrain the resident to his/her wheelchair as a form of discipline to control the resident's behavior. The facility's census was 45.The administrator was notified on 04/27/26 of Past Non-Compliance which occurred on 04/16/26, when staff reported CNA A restrained the resident with a sheet to his/her wheelchair. On 04/16/26, staff assessed the resident for physical and psychological harm, the administrator investigated the allegation, notified the required parties and agencies, re-educated staff on the facility's abuse and neglect policy, and immediately terminated CNA A. 1. Review of the facility's Abuse Policy, dated 01/01/24, showed abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish. Willful, as used in this definition of abuse means the individual must have deliberately, not that the individual must have intended to inflict injury or harm. Review showed: -Physical abuse includes hitting, slapping, pinching, kicking or controlling behavior;-The governing body of the facility will ensure that each resident is free from abuse and physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms;-Any staff member found guilty of abuse will be immediately terminated as an employee of the facility. 2. Review of Resident #1's admission Minimum Data Set (MDS), a federally required assessment, dated 04/07/26, showed staff assessed the resident as follows: -Severe cognitive impairment;-Diagnoses to include non-Traumatic Brain dysfunction, anxiety disorder, and Schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves);-Used a walker for ambulation. Review of the resident's care plan, dated 03/26/26, showed staff were directed to assist the resident with ambulation and transfers utilizing therapy recommendations, utilize devices as appropriate to ensure safety, provide clear, simple instructions, and provide re-orientation to surroundings and environment. Review of the facility's investigation, dated 04/16/26, showed Licensed Practical Nurse (LPN) D reported to the administrator CNA A restrained Resident #1 to his/her wheelchair with a sheet, and CNA B reported he/she witnessed the incident. Staff assessed the resident with no injuries, the administrator reported the allegations of physical abuse and restraint to all necessary parties, and immediately terminated CNA A. The administrator documented CNA A was terminated on 04/16/26 for employee conduct and abuse, after CNA A tied a sheet around a resident, used his/her foot to tighten it and restrained the resident in his/her wheelchair, then placed a blanket over the back of the chair to hide it. During an interview on 04/27/26 at 9:30 A.M., the administrator said during his/her investigation CNA A admitted to him/her via phone that he/she tied the resident to the chair to teach the resident a lesson, and he/she immediately terminated CNA A via phone for abuse. During an interview on 04/27/26 at 10:29 A.M., CNA C said CNA A was headed outside to smoke and told him/her that he/she had restrained the resident and Licensed Practical Nurse (LPN) D was aware, but CNA A did not say how he/she restrained the resident. CNA C said when he/she saw the resident in the dining room a few minutes later, the resident was in a wheelchair with a blanket around him/her and looked normal, and LPN D<br>(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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | was next to the resident fidgeting under the blanket. CNA C said he/she did not see CNA A tie the resident to the wheelchair. During an interview on 04/27/26 at 10:45 A.M., CNA A said he/she placed a sheet across the resident's upper body, tied the sheet to the back of the wheelchair, pushed the resident to the dining room, went outside to smoke, and planned to untie the resident when he/she returned from outside. CNA A said he/she restrained the resident to the wheelchair with the sheet to trick the resident's mind so he/she would not keep getting up. CNA A said he/she had received training on abuse and neglect, knew it was not appropriate to restrain the resident, and should not have restrained him/her with the sheet, but did not intend to hurt or abuse the resident, and the resident was not harmed. CNA A said he/she was fired the same night for abuse and now understands that when he/she restrained the resident with the sheet, it was a form of abuse. During an interview on 04/27/26 at 11:36 A.M., LPN D said he/she left CNA A and CNA B in the resident's room to get the resident ready for dinner. LPN D said CNA A pushed the resident in a wheelchair to the dining room, and CNA B approached the nurses' desk and told him/her what he/she had witnessed. LPN D said the resident had a blanket draped over the back of the wheelchair, so the sheet tied behind the chair was not obvious, and it took him/her a few mins to untie the knot from the sheet. LPN D said CNA A told him/her he/she had tied the resident to the chair with the sheet, he/she educated CNA A regarding restraints, and reported the incident to the oncoming nurse and the administrator. During an interview on 04/30/26 at 10:52 A.M., CNA B said he/she witnessed CNA A tie the resident to the wheelchair with a sheet and tried to tell CNA A he/she could not restrain the resident, but CNA A did it anyway and used his/her foot to help tighten the sheet to the back of the chair. CNA B said he/she knew a restraint is a form of abuse, so he/she immediately reported what he/she saw to LPN D, LPN D un-tied the sheet from the resident and re-educated staff they could not restrain a resident. Intake# 2986327 |

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| | 265760 | A. Building<br>B. Wing | 04/27/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Fulton Manor Care Center | 520 Manor Drive<br>Fulton, MO 65251 |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement policies and procedures to prevent abuse, neglect, and theft.<br><br>Based on record review and interview, facility staff failed to complete a Criminal Background Check (CBC) for three employees (Certified Nurse Assistant (CNA) A, CNA B, and CNA C), out of three sampled employees, as required by the Missouri Department of Health and Senior Services (DHSS) and facility policy. The facility's census was 45.1. Review of the facility's Abuse, Neglect and Exploitation policy, dated 01/31/24, showed potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property. The facility will maintain documentation of proof that the screening occurred. Review of the facility's Background Screening Investigations policy, dated 03/2019, showed Our facility conducts employment background screening checks, reference checks and criminal conviction investigation checks on all applicants for positions with direct access to residents (direct access employs). The director of personnel, or designee, conducts background checks, reference checks and criminal conviction checks (including fingerprinting as may be required by state law) of all potential direct access employees and contractors. Background and criminal checks are initiated within two days of an offer of employment or contract agreement, and completed prior to employment. 2. Review of CNA A's employee file showed a hire date of 08/25/25 and did not contain documentation staff requested or received results of a CBC. 3. Review of CNA B's employee file showed a hire date of 09/22/25 and did not contain documentation staff requested or received results of a CBC. 4. Review of CNA C's employee file showed a hire date of 08/14/25 and did not contain documentation staff requested or received results of a CBC. 5. During an interview on 04/27/26 at 1:20 P.M., the administrator said he/she is responsible for requesting CBCs on all potential staff prior to hire. The administrator said he/she normally verifies if the applicant is registered with the Family Care Safety Registry (FCSR), and if they are not, then he/she sends a request to Missouri Association of Nursing Home Administrators (MANHA) to complete a background check, but if they are already registered with the FCSR, he/she does not request a CBC. The administrator said he/she has not requested a CBC from the Missouri State Highway Patrol (MSHP) since he/she took over the responsibility to request employee CBCs in April 2025. Intake # 2986327 |