STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265760	A. Building B. Wing	06/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fulton Manor Care Center	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)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to issue an appropriate emergency discharge notice for one resident (Resident #1) when the emergency discharge notice did not contain a location and failed to notify the Ombudsman of the emergency discharge to the hospital and refused to allow him/her to return to the facility when discharged from the hospital. The facility census was 48. 1. Review of the facility's Transfer or Discharge Emergency policy, dated 08/18, showed it did not direct staff in regard to appropriate discharge location, or in regards to contact information for the Ombudsman noted on the discharge to allow for an appeal when issuing an emergency transfer or discharge notice. 2. Review of Resident #1's face sheet, dated 6/15/26, showed the resident admitted to the facility on [DATE] and staff discharged him/her to the local hospital on 5/18/26.Review of the facility's emergency discharge notice, dated 05/18/26, showed staff documented the notice effective on 05/18/26 and the resident transferred/discharged to the hospital.During an interview on 06/15/26 at 12:53 P.M., the administrator said the resident was sent to the hospital after making statements of self-harm and threatening staff with physical harm. He/She said the facility refused the resident to return to the facility, due to his/her threatening behaviors toward staff and concern for the safety of other residents. He/She said staff did not attempt to find the resident a new facility after the resident was transferred to the hospital and after refusing to allow the resident to return to the facility. He/She said he/she did not contact the ombudsman. #3024553#3031434

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