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	10/02/2024

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 27152 Based on record review and interview, facility staff failed to ensure two residents (Resident #1 and Resident #2) remained free from sexual abuse when Resident #1 raised his/her shirt, and Resident #2 touched his/her chest inappropriately. The facility census was 34. The administrator was notified on 10/15/24 of past Non-Compliance which occurred on 9/30/24. On 9/29/24, Certified Medication Technician (CMT) B, notified Registered Nurse (RN) A he/she witnessed Resident #1 in Resident #2's room. He/She reported he/she observed Resident #1 with his/her shirt raised, and Resident #2 touched Resident #1's chest inappropriately. Staff immediately separated the residents, assessed the residents for injuries, moved Resident #1 to a secured unit, and notified the required parties and agencies. The Director of Nursing (DON) inserviced all staff on duty, and all staff prior to working, on new interventions, assessing residents for the ability to consent to sexual activity, and abuse and neglect policies and procedures. 1. Review of the facility's Abuse, Neglect, and Misappropriation Policy, undated, showed it is the policy of the facility to prevent abuse by providing residents, families, and staff information on how and to whom to report concerns and grievances without fear of reprisal or retribution. Review showed the facility will establish a safe environment that supports, to the extent possible, a resident's sexual relationship and by establishing policies and protocols for preventing sexual abuse, such as the identify when, how, and by whom determinations of capacity to consent to sexual contact will be made, and where the documentation will be recorded. Review showed staff directed to identify, assess, care plan appropriate interventions, and monitor residents with behaviors that include sexually aggressive behavior such as saying sexual things and inappropriate touching/grabbing. Review showed: - Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting harm, pain, or mental anguish; - Willful is defined as the individual acting deliberately, not that the individual intended to inflict harm or injury; - Sexual abuse includes, but is not limited to unwanted sexual attention touching, or sexual touching of the body of a resident who cannot make decisions for themselves. (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 Level of Harm - Actual harm Residents Affected - Few	2. Review of Resident #1's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 9/10/24, showed staff assessed the resident with impaired cognition. Review of the resident's face sheet showed the resident is his/her own responsible party, with diagnoses of Unspecified Dementia, Psychotic Disturbance, Mood Disturbance, and Anxiety. Review of the resident's plan of care, updated 9/30/24, showed staff documented on 9/30/24, staff moved the resident to the special care unit of the facility, and staff are directed to monitor him/her closely, and redirect unwanted behaviors. Review of Resident #1's nurses' notes, dated 9/29/24, showed RN A documented staff observed Resident #1 in Resident #2's room with his/her shirt raised, with his/her chest exposed. Staff documented Resident # 1, was allowing, Resident #2 to touch his/her chest inappropriately, and he/she was, shocked and quickly pulled his/her top down. 3. Review of Resident #2's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 8/29/24, showed staff assessed the resident with impaired cognition. Review of the resident's face sheet showed the resident has an active Durable Power of Attorney (DPOA), and diagnoses of Unspecified Dementia, anxiety disorder, and Alzheimer's Disease. Review of the resident's plan of care, updated 9/30/24, showed staff documented to conduct frequent checks on the resident to ensure the resident did not have the opposite gender in his/her room. When the resident talks to staff or other residents in a sexual manner, staff will redirect him/her and remind him/her this is not acceptable. Review of Resident #2 nurses' notes, dated 9/29/24, showed RN A documented staff observed Resident #2's door closed. Staff knocked and asked to enter Resident #2's room, Resident #2 had his/her hands on Resident #1's chest. 4. Review of the facility's investigation summary, dated 9/30/24, showed staff documented staff reported Resident #1 in Resident #2's room. He/She had his/her shirt up, and Resident #2's hands were on Resident #1's chest. Review showed staff documented both residents with cognitive impairment, and neither resident recalls the incident. Review showed Certified Nurse Aide (CNA) C documented he/she and Certified Medication Technician (CMT) B knocked on Resident #2's door, and upon entrance observed Resident #2 on Resident #1's bed with his/her chest exposed. Review showed CMT B documented he/she knocked on Resident #2's door and witnessed Resident #1 sitting on the bed with his/her shirt up and Resident #2 in between Resident #1's legs, touching Resident #1's chest inappropriately. During an interview on 9/30/24, at 3:35 P.M., the administrator said RN A notified the Director of Nursing (DON) staff observed Resident #2 touching Resident #1's chest inappropriately in Resident #2's room. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 9/30/24, at 3:40 P.M., the DON said staff notified him/her staff observed Resident #2 touching Resident #1's chest inappropriately in Resident #2's room. He/She said both residents are alert and oriented with some confusion. He/She said when he/she contacted Resident #1's next of kin, the next of kin said the incident did not surprise him/her, and the resident's behaviors are consistent with the resident's personality. The DON said when staff notified Resident #2's spouse regarding the incident, the resident's spouse was upset. During an interview on 9/30/24, at 3:50 P.M., CMT B said he/she knocked on Resident #2's door and witnessed Resident #1 sitting on the bed with his/her shirt up and Resident #2 in between Resident #1's legs, touching Resident #1's chest inappropriately. He/She said he/she immediately notified RN A who separated the residents. During an interview on 10/02/24 at 2:32 P.M., RN A said CMT B and CNA C notified him/her they observed Resident #2 touching Resident #1's chest inappropriately in Resident #2's room. He/She said he/she went to Resident #2's room, both residents appeared shocked, but not distraught, and Resident #1 lowered his/her shirt. RN A said he/she immediately separated the residents, and began his/her investigation and report. During an interview on 10/04/24 at 8:03 A.M., CNA C said he/she and CMT B went into Resident #2's room. He/She said he/she looked over CMT B's shoulder and observed Resident #1 with his/her shirt raised, exposing his/her chest. He/She said he/she did not see Resident #2 physically touch Residnet #1. He/She said he/she and CMT B immediately reported the situation to RN A. CNA C said he has not observed either resident be physically inappropriate with any other residents. MO00242810