STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fulton Nursing and Rehabilitation, LLC	1004 Holiday Lane Fulton, KY 42041

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on interview, record review, and review of the facility policy, the facility failed to complete a pre-admission screening and resident review (PASARR) for individuals with a mental disorder prior to admission for 1 of 3 residents (Resident (R)14). Additionally the facility failed to refer R14 for a Level II PASARR following inpatient psychiatric treatment on 11/01/2024, 2 days following admission to the facility, and again on 02/28/2025. The findings include: Review of the facility policy, Resident Assessment-Coordination with PASARR Program, revised on 03/14/2023, revealed the facility would coordinate assessments with the PASARR program. Per review, coordinating the assessments with the PASARR program was to ensure individuals with a mental disorder, intellectual disability, or a related condition received care and services in the most integrated setting appropriate to their needs. Continued review revealed all applicants to the facility were to be screened for serious mental disorder or intellectual disabilities (ID) and related conditions in accordance with the state Medicaid rules for screening. Policy review revealed a PASARR Level 1 was the initial pre-screening that was completed prior to admission. Further review revealed, any resident who exhibited a newly evident or possible serious mental disorder, intellectual disability or a related condition, was to be referred promptly to the state mental health or ID authority for a Level II resident review. In addition, review revealed examples listed included a resident exhibiting behavioral, psychiatric, or mood related symptoms, that suggested the presence of a mental disorder where dementia was not the primary diagnosis. Review further revealed a resident transferred, admitted or readmitted to the facility following an inpatient psychiatric stay or equally intensive treatment was also to be referred. Review of the Resident Face Sheet for R14, revealed the facility admitted the resident on 10/30/2024, with diagnoses to include: schizophrenia, unspecified; depression, unspecified; and generalized anxiety disorder. Review of the Quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 03/04/2025, revealed the facility assessed R14 to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating the resident was cognitively intact. In interview with R14 on 05/20/2025 at 11:20 AM, she stated she had been at the facility for about six months. She said she previously lived at a personal care home; however, had gotten pneumonia and went to the hospital. R14 reported she came to the facility from the hospital. She stated the facility had sent her out for what they called behaviors twice since she had been admitted at the facility. R14 further stated she did not know what a PASARR assessment was. (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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing (DON) on 05/22/2025 at 3:37 PM, she stated she had been the facility's interim DON since 05/06/2025. She said she thought admissions staff and the social worker were supposed to do the PASARR assessments. The DON explained the admission Director usually got the resident referral and was to check the resident's history. She stated a diagnosis of schizophrenia might trigger a Level II PASARR assessment; however, she did not think it meant they needed one. The DON further stated the facility had a mental health provider that took care of most of the mental health things. She additionally stated R14 probably should have had a Level II PASARR assessment completed. In interview with the Administrator on 05/22/2025 at 4:08 PM, she stated she was responsible for completing the PASARR Level I assessments, and that was completed on the day of a resident's admission. She said the PASARR asked about the resident's diagnoses, change in conditions or change in function. The Administrator stated hospitalization on a behavioral health unit (BHU) would not indicate a PASARR Level II assessment needed to be completed. She further stated she was unable to recall what R14's behaviors had been when she was sent to the BHU on 11/02/2024 and on 02/18/2025.

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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. Based on interview, record review and review of the facility policy, the facility failed to review and revise the comprehensive care plan (CCP) following readmission to the facility from a behavioral health unit (BHU) for 1 of 24 sampled residents, (Resident (R)14). The findings include: Review of the facility policy, Comprehensive Care Plans revised 02/20/2025, revealed it was the facility's policy to develop and implement a comprehensive person-centered care plan for each resident consistent with resident rights. Continued policy review revealed the comprehensive person-centered care plan was also to include measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that had been identified in the resident's comprehensive assessment. Further review revealed the CCP was to be reviewed and revised by the interdisciplinary team (IDT) after each comprehensive and quarterly Minimum Data Set (MDS) Assessment. Review of the Resident Face Sheet for R14, revealed the facility admitted the resident on 10/30/2024, with diagnoses that included: generalized anxiety disorder; schizophrenia, unspecified and depression, unspecified. Review of the Quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 03/04/2025, revealed the facility assessed R14 as having a Brief Interview for Mental Status (BIMS) score of 15 of 15, that indicated the resident was cognitively intact. Review of the Comprehensive Care Plan dated 11/01/2024 for R14, revealed the facility had identified a focus problem for behavioral symptoms for the resident related to resisting care, activities of daily living (ADL) care, medications, treatments, showers, urinating on the floor, and liking to sit on the floor. Per review, the goals statement read, resident would not exhibit resistance to care. Continued review revealed the interventions dated 11/01/2024 included: involving R14 in her care; administering medications as ordered and observing for effectiveness; and reporting any adverse side effects. Further review of the 11/01/2024 interventions revealed: allowing R14 to choose options, explain the consequences of refusal of therapy, medications, and care; maintaining a calm approach and environment for the resident. In addition, review of the interventions revealed to obtain a psych consult/psychosocial therapy; praising R14 when her behavior was appropriate; and when the resident began to resist care, stop and try the task later, and do not force the resident to do the task. In interview on 05/20/2025 at 11:20 AM, R14 stated she had been admitted to the facility for about six months. R14 said she previously lived at a personal care home, but got pneumonia and was transferred to the hospital. She stated she was admitted to the facility after being discharged from the hospital. R14 reported the facility had sent her out (to a behavioral health unit) for what they called behaviors two times since she had been admitted to the facility. She further stated she did not know what a PASARR assessment was. Review of the hospital Discharge Summary dated 02/28/2025, revealed a referral had been made to the BHU from the patient's (P14's) skilled nursing facility (SNF) due to her, seeing people in her bathroom, threatening to kill her roommate, and threatening to harm herself. Per review, the SNF staff reported R14's Celexa (antidepressant) and risperidone (antipsychotic) were recently increased due to the patient's agitation, verbal impulsivity, and risk to self and others, with no change in her (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	behavior. Continued review revealed R14 was admitted to the BHU for medical stabilization. Further review revealed under, My Safety Plan it was noted R14 had schizophrenia symptoms and confusion. Additional review of the My Safety Plan section the goals for R14's healthy behavior included: referring her to be seen by the in house psychiatric (psych) provider; encouraging her to participate in daytime activities; avoiding caffeine in the evening; pairing her with a roommate that she would get along with; and have others remind her she was in a safe place. Review of the Nursing Progress Note dated 02/15/2025 at 9:29 PM for R14, revealed the resident was convinced people were after her, and kept calling staff into her room saying someone was in the bathroom and trying to get her. Per review, staff reassured R14 no one was in the restroom and she was safe. Continued review revealed R14 began screaming that her roommate had a fork and was going to try to kill her and she was afraid. Further review revealed the nurse explained to R14 that her roommate had a fork to eat her food with. In addition, review revealed R14 then screamed no one needs a fork, and proceeded to exit the room to sit at the nurse's station. Review of the Nursing Progress Note dated 02/15/2025 at 9:36 PM for R14, revealed the resident kept asking for the phone to call the police, saying people were after her. Further review revealed staff continued to reassure R14 she was safe here: (at the facility) and no one was after her. Review of the Nursing Progress Note dated 2/16/2025 at 4:25 PM for R14, revealed the resident continued to act out towards employees by stating she was going to hurt them if she did not get what she asked for. Further review revealed R14 wanted the cordless phone which was being used by another resident. Review of the Nursing Progress Note dated 02/16/2025 at 10:01 PM for R14, revealed the resident continued with behaviors towards staff, threatening to harm staff if they did not do what she said. Further review revealed R14's anger was only directed at staff at that time, and had shown no anger toward other residents at the time. Review of the Nursing Progress Note dated 02/17/2025 at 9:57 AM for R14, revealed the resident's increased behaviors, aggression, and paranoia continue. Review of the Nursing Progress Note dated 02/18/2025 at 3:36 PM for R14, revealed a new order was received to send the resident to the behavioral health center for treatment secondary to hallucinations, delusions and threatening behavior towards staff and others. Per review, the nurse left a voicemail with a hospital BHU with no response received at the time. Further review revealed the nurse called another geriatric psychiatric behavioral health center and gave information on R14, as well as faxing the information, and was awaiting a return call. Review of the Nursing Progress Note dated 02/18/2025 at 5:37 PM for R14, revealed, I have called the ambulance to transport resident to the BHU's emergency room (ER) for evaluation for admittance to the BHU. Review of the Comprehensive Care Plan dated 11/01/2024 for R14, revealed the facility failed to revise the resident's care plan with her documented behaviors. In interview with the Interim Director of Nursing (DON) on 05/22/2025 at 3:37 PM, she stated a resident's care plan was to be reviewed and revised by the facility's interdisciplinary team (IDT) when the resident returned from a hospital stay. She said the care plan as a whole was to be reviewed, (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and said the purpose of the care plan was for it to reflect all of the care for the resident. The DON reported she expected residents' behaviors to be noted on their care plan, both current behaviors and the history of any behaviors. She further stated R14's care plan should have included documentation of her behaviors and her diagnosis of schizophrenia. The DON additionally said she thought residents' care plans should be followed, and the CNA's were told of new changes regardless. In interview with the Administrator on 05/22/2025 at 4:08 PM, she stated care plan were reviewed and revised daily in the facility's daily clinical meeting. She reported residents' care plans were based and built off of each resident's needs. The Administrator further stated if residents had specific problems those should be placed on their care plan. She also said she expected staff to residents' revise care plans when needed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and review of facility policy, the facility failed to store foods in accordance with professional standards for food service safety. Observation during the initial kitchen tour on 05/20/2025 at 9:05 AM, with the Dietary Manager, revealed multiple items stored in the reach in cooler that were not labeled or dated or the use by date had passed. The findings include: Review of the facility policy, Food Storage: Cold, undated, revealed, it was the facility's policy to ensure all time temperature control for safety, frozen and refrigerated food items to be appropriately stored in accordance with the guidelines of the Food and Drug Administration's (FDA's) Food Code. Continued review revealed all food items were to stored properly in covered containers, labeled and dated and arranged in a manner to prevent cross contamination. Observation of the facility's kitchen area on 05/20/2025 at 9:05 AM, revealed in the reach in cooler three opened containers of blackberries that were dried out, not labeled or dated and covered with a white substance. Continued observation of the reach in cooler revealed two (2) containers of opened blueberries, that were dried out, not labeled or dated and contained mold; a container with three hard boiled eggs that was not labeled or dated; and a bowl of white rice with a use by date of 05/11/2025 (nine days prior to the observation). In interview with the Dietary Manager on 05/20/2025 at 9:30 AM, he stated all items were to be labeled and dated prior to being stored in the coolers. He stated all kitchen staff were responsible for checking the coolers each day; however, it was not a task assigned to anyone specifically. The DM further stated he expected all kitchen staff to follow policies and guidelines. He also stated residents could become ill if served food that was expired or not stored properly. In interview with the Administrator on 05/22/2025 at 4:08 PM, she stated she expected the food services staff to follow their guidelines. She stated all food items should be labeled and dated before being stored. The Administrator further stated outcomes for patients were that they could become sick if served food that was not stored properly.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and review of facility policy, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 24 sampled residents (Resident (R)3). The findings include: Review of the facility policy, Infection Prevention and Control Program, revised 01/2025, revealed the facility would establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Continued review revealed all staff should assume all residents were potentially infected or colonized with an organism that could be transmitted. Per review, during the course of providing resident care, hand hygiene should be performed in accordance with the facility's established hand hygiene procedures. Further review revealed all staff should use personal protective equipment (PPE) according to the established facility policy governing the use of PPE. Review of the facility policy, Hand Hygiene, dated 03/22/2022, revealed, all staff were to perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. Further review revealed that applied to all staff working in all locations within the facility. Review of the facility policy, Perineal Care, dated 12/20/2020, revealed, it was the practice of the facility to provide all incontinent residents' perineal care during routine bathing and as needed. Per review, the provision of incontinent care was in order to promote cleanliness and comfort; prevent infection to the extent possible; and prevent and assess for skin breakdown. Continued review revealed perineal care referred to the care of the external genitalia and anal areas. Further review revealed staff were to perform hand hygiene and put on gloves, and apply other PPE as appropriate. In addition, review revealed staff were to cleanse a resident's buttocks and anus from front to back, vagina to anus in females using a separate washcloth or wipe. Review of the facility policy, Handling Soiled Linen, revised on 06/12/2023, revealed it was the facility's policy to handle, store, process, and transport linen in a safe and sanitary method to prevent the spread of infection. Per review, all used linen should be handled using standard precautions and treated as potentially contaminated. Continued review revealed used or soiled linens should be collected at the bedside and placed in a linen bag or a designated lined receptacle. Review of the admission Face Sheet for R3 revealed the facility admitted the resident on 02/23/2025, with diagnoses to include: unspecified dementia, mild without behavioral disturbance; hypertension; and depression. Review of the Quarterly Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 05/07/2025, revealed a Brief Interview for Mental Status (BIMS) score of three out of 15, indicating severe cognitive impairment. Observation on 05/21/2025 at 10:05 AM, revealed LPN 1 told the State Survey Agency (SSA) Surveyor R3 needed assistance, and the the SSA Surveyor knocked on the resident's door, and went in the room, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3 was observed standing and holding onto the overbed table. Per observation, R3 had no pant on and her socks appeared to be wet. When the SSA Surveyor observed the left side of R3's bed the floor was wet and the resident's pants were lying on the floor. LPN 1 was then observed to enter R3's room wearing PPE, which included a gown, face mask, and gloves, although the resident was not on any type of precautions. Per observation, LPN 1 wet two (2) washcloths in the sink; however, did not assist R3 to the bed or provide privacy for the resident. Continued observation revealed LPN 1 took a wet washcloth and wiped R3's buttock area, then using the same washcloth, she wiped between R3's legs, and threw the soiled washcloth to the floor. Further observation revealed LPN 1 dried R3 with a towel then threw the towel on the floor with the soiled washcloths. In addition, observation revealed LPN 1 went to the closet, and without removing her gloves, opened R3's closet and obtained a clean brief and proceeded to dress the resident in a facility gown. Observation further revealed LPN 1 then removed her face mask and gown, obtained the soiled linen from floor and placed it in a linen bag and doffed her soiled gloves. In interview with LPN 1 on 05/21/2025 at 3:49 PM, when asked about providing perineal care, she stated she had worked as a nurse's aide, but she had never gotten certified. LPN 1 stated she had worn PPE when providing R3's care as she thought it was required if the resident was on enhanced barrier precautions (EBP). She said she wiped R3 using a washcloth starting with the back (buttock area) then moved to the resident's front. LPN 1 reported she threw the soiled washcloths and towel on the floor; however, should not have done that. She stated she had not been paying attention to what she was doing and was just trying to get the job done. LPN 1 stated further stated she could not remember in what order she removed her PPE, but should have removed her gloves first. In interview with the Director of Nursing (DON) on 05/22/2025 at 3:37 PM, she stated she had been the DON since 05/06/2025. She said she expected all staff to provide care the residents needed in the proper manner. The DON further stated all staff were expected to follow the facility's infection control policy and guidelines when providing residents' incontinence care. She additionally said that included appropriately donning and doffing PPE, handling soiled linens and performing hand hygiene. In interview with the Administrator on 05/22/2025 at 4:08 PM, she stated she expected staff to provide proper incontinence care for residents, and follow the facility's infection control guidelines. She said she expected staff to follow the appropriate steps when donning (applying) and doffing (removing) their PPE. The Administrator reported soiled linens were not to be placed on the floor and she expected staff to dispose of soiled linens in the appropriate manner. She further stated all staff were expected to follow the facility's infection control policies and procedures.