

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/25/2025
NAME OF PROVIDER OR SUPPLIER  Warrenton Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  65 State Hwy Aa Wright City, MO 63390	

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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, interview, and record review, facility staff failed to complete shiftily controlled drug counts with two staff members per facility policy to prevent misappropriation and assure correct controlled drug counts. The facility census was 92. The administrator was notified on 11/25/25 of past Non-Compliance which occurred on 10/25/25 when the administrator implemented new policies and procedures to ensure Certified Medication Technician (CMT) and nurses counted narcotics at the beginning and end of each shift with two staff members and documented on the Narcotic Count Form. Staff were in-serviced on 10/25/25 regarding counting narcotics at the beginning and end of each shift with two staff members and documented on the Narcotic Count Form. 1. Review of the facility's Narcotic Count policy, dated undated, showed staff are directed as follows:-The purpose is to complete a physical inventory of narcotics at each shift change to identify discrepancies. -One Registered Nurse (RN), Licensed Practical Nurse (LPN), or CMT going off duty AND one RN, LPN, or CMT coming on duty must count and justify accuracy of narcotics supply for each individual resident at the change of each shift.-Narcotic records are reconciled by a physical count of the remaining narcotic supply at each shift change by the incoming and outgoing licensed nurse. Records are to be retained for at least one year. -After the supply is counted and justified, the nurse/CMT records the date and his/her signature, verifying that the count is correct. 2. Review of facility's investigation, dated 10/25/25, showed facility staff documentd the narcotic log sheet identified two missing controlled medications. Facility staff found the missing medications to be related to medications not accurately signed out per policy and did not identify misappropriation of any narcotic controlled medications. 3. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 11/02/25, showed staff assessed the resident as:-Moderately cognitively impaired;-Received a pain medication as needed during the seven day look back period;-Used an opioid medication. Review of the resident's progress notes, dated 10/22/25, showed staff documented the resident transferred to the hospital. Review of the resident's progress notes, dated 10/28/25, showed staff documented the resident returned from the hospital. Review of the resident's Physician Order Summary (POS), undated, showed an order for Tramadol (treats pain) 100 milligrams twice a day. Review of the resident's controlled substance log, dated 10/22/25 through 10/25/25, showed controlled substance log did not contain documentation staff counted the resident's Tramadol medication. Review showed the 16 pills remained on 10/22/25 and 14 pills remained on 10/25/25. Review of the facility's Controlled Substance Shift Change Form for upper 100 hall, dated 10/01/25 through 10/31/25, showed:-10/01/25, one staff signature for 7:00 A.M.;-10/02/25, one staff signature for 11:00 P.M.;-10/03/25, one staff signature for 7:00 A.M. and 11:00 P.M.;-10/04/25, one staff signature for 7:00 A.M.;-10/05/25, one staff signature for 11:00 P.M.;-10/06/25, one staff signature for 7:00 A.M. and 11:00 P.M.;-10/07/25, one staff signature for 7:00 A.M. 3:00 P.M. and no signatures for 11:00 P.M.;-10/08/25, one staff signature for 7:00 A.M. and 3:00 P.M.;-10/09/25, one staff signature for 3:00 P.M. and 11:00 P.M.;-10/10/25, one staff signature for 7:00 A.M. 3:00 P.M. and no signatures for 11:00 P.M.;-10/11/25, one staff signature for 7:00 A.M. and no signatures for 11:00 P.M.;-10/12/25, one staff signature for 7:00 A.M., no signatures for 3:00 P.M. and 11:00 P.M.;-10/13/25, one staff signature for 7:00 A.M. and 3:00 P.M.;-10/14/25, one staff signature for 3:00 P.M. and 11:00 P.M.;-10/15/25, one staff signature for 7:00 A.M., 3:00 P.M., and 11:00 P.M.;-10/16/25, one staff signature for 7:00 A.M., 3:00 P.M. and 11:00 P.M.;-10/17/25, one staff signature for 7:00 A.M., 3:00 P.M. and no signatures for 11:00 P.M.;-10/18/25, one staff signature for 7:00 A.M. and 11:00 P.M.;-10/19/25, one staff signature for 7:00 A.M. and 11:00 P.M.;-10/20/25, one staff signature for 7:00 A.M.;-10/21/25, one staff signature for 11:00 P.M.;-10/22/25, one staff signature for 7:00 A.M. and 11P.M.;-10/23/25, one staff signature for 7:00 A.M. and 11:00 P.M.;-10/24/25, one staff signature for 7:00 A.M., 3:00 P.M. and 11:00 P.M.;-10/25/25, one staff signature for 7:00 A.M. and no signatures for 3:00 P.M.;-10/26/25, one staff signature for 3:00 P.M. and no signature for 11:00 P.M.;-10/27/25, one staff signature for 7:00 A.M. and 3:00 P.M.;-10/28/25, one staff signature for 3:00 P.M.;-10/30/25, one staff signature for 7:00 A.M. and 11:00 P.M.;-10/31/25, one staff signature for 7:00 A.M. and 11:00 P.M. During an interview on 11/24/25 at 12:29 P.M., CMT A said staff are educated to complete a narcotics count at the beginning and end of each shift with two staff members and initial the count as correct on the Controlled Substance Shift Change Form. He/She said if medications were discovered missing, staff should report to the charge nurse. He/She said he/she and CMT B both had the key for his/her medication cart. He/She said it was busy when they came to work, so they did not have an opportunity to count the narcotic medication. He/She said when they did have an</p>		