

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 02/26/2026
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to use appropriate infection control procedures to prevent the spread of bacteria or other infectious causing contaminants when staff failed to apply the appropriate Enhanced Barrier Precautions (EBP) during care for one resident (Resident #3) of three sampled residents with wounds and ensure Personal Protective Equipment (PPE) was in proximity of the resident room for three of three sampled residents with wounds (Resident #3, #2 and #11). The facility census was 91.1. Review of the facility's EBP to Infection Control Guidance, dated March 2024, showed:-EBP should be implemented for the period of the resident's stay or until wounds have resolved or indwelling medical devices have been removed;-EBP should be used with residents with an indwelling medical device including the following: urinary catheter, feeding tube, and tracheostomy (tube inserted into the neck for breathing);-EBP should be used with residents with a wound regardless of their infection status;-EBP should be used when providing high-contact resident care activities such as: bathing/showering, transferring residents from one position to another; providing hygiene, changing bed linens, changing briefs or assisting with toileting, caring for or using an indwelling medical device, performing wound care;-EBP equipment includes a gown and gloves;-Residents placed on EBP should have PPE in proximity outside the door and a trash can in the resident's room for disposal prior to leaving the room.2. Review of Resident #3's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 02/15/26, showed staff assessed the resident as cognitively impaired, dependent on staff for transfers, and with one unhealed Stage III pressure ulcer(deep wound exposing fat).Observation on 02/26/26 at 10:32 A.M., showed Certified Nurse Aide (CNA) A and Certified Medication Technician (CMT) B enter the residents room to transfer the resident from the bed to a shower chair. A sign hung on the door to use EBP for high-contact care to include transfers. The residents' room did not have PPE within close proximity. CNA and CMT applied gloves and rolled the resident to his/her side and placed a mechanical lift sling under the resident. Observation showed a wound to the resident's upper buttocks area. The CNA and CMT transferred the resident to his/her chair. The CNA and CMT did not wear a gown during the transfer or direct resident contact. During an interview on 02/26/27 at 10:45 A.M., CMT B said EBP are used when a resident has a catheter, colostomy or wound. He/She said he/she should have worn a gown and gloves during the residents' transfer and care. He/She said he/she didn't know the resident had a wound and is normally passing medication to residents and not providing direct care. He/She didn't see the sign on the door. During an interview on 02/26/27 at 11:36 A.M., CNA A said staff should wear a gown and gloves if they are told the resident needs them. He/She said Resident #3 did not need EBP since he/she did not have an infection such as Clostridium difficile (c-diff), an infection of the colon, shingles (rash caused by same virus as chickenpox) or Methicillin Resistant Staphylococcus Aureus (MRSA), a resistant bacterium from antibiotic use. He/She said he/she has been employed at the facility for six months and has received EBP training. He/She said the sign on</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 265181	Facility ID: 265181 If continuation sheet Page 1 of 2

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 02/26/2026
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>the door is an old sign and didn't apply to the resident. During an interview on 2/26/27 at 11:26 A.M., the Director of Nursing (DON) said he/she was not aware the aides did not apply appropriate PPE during a transfer of a resident with a wound.3. Review of Resident #2's quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively intact with one unhealed stage III pressure ulcer.Observation on 02/26/26 at 12:01 P.M., showed the door to Resident #2's room contained a sign the resident required EBP for high-contact care. PPE was not observed in proximity of the room. or on a rack on the door inside the room. During an interview on 02/26/26 at 11:42 A.M., the resident said he/she has a wound on his/her bottom. 4. Review of Resident #11's Quarterly MDS, dated [DATE] showed staff assessed the resident as cognitively intact with one unhealed stage III pressure ulcer. Observation on 02/26/26 at 10:06 A.M., showed a sign on the resident's door indicated EBP needed for high-contact resident care. PPE was not observed in proximity of the door or a rack inside the room. During an interview on 02/26/26 at 10:06 A.M., the resident said he/she has wounds on his/her legs and feet.5. During an interview on 02/26/26 at 12:15 P.M., the Director of Nursing (DON) said EBP is used for residents with wounds, catheters, or other indwelling/medical devices. The resident should have a sign on the door alerting staff the need to use EBP and a cart or isolation supplies should be by the resident's door. The DON said it depends on why the resident requires EBP if the staff should use a gown during transfers. The DON said Resident #3 would require EBP since he/she has a wound. He/She said he/she has only been in the DON role for four days and did not know staff were not wearing the appropriate EBP. During an interview on 02/27/26 at 11:26 A.M., the Infection Preventionist (IP) also RN charge nurse said EBP should be followed, to include use of a gown and gloves, for catheter care, wound care, colostomy care and with any direct resident contact with such devices. A sign should be posted on the door to alert staff there is resident in the room that requires the extra PPE. There should also be a rack that hangs on the door with the needed PPE contained inside it to alert staff to apply the necessary equipment for care. Staff should apply antibacterial solution prior to entering the room which is on the walls outside the resident rooms. The IP said if there is no gown or gloves in the resident room, staff are expected to go to the storage closet or linen closet to apply it prior to performing any care. PPE is to be removed and placed in the regular trash prior to leaving the resident room after care is given. The trash is then removed from the room. The IP said the floor charge nurse is expected to ensure compliance with use of EBP. Complaint #2734139</p>		