STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265181	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warrenton Manor	65 State Hwy Aa Wright City, MO 63390

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility staff failed to update the plan of care with changes in care needs for two residents (Resident #1 and Resident #2) out of three sampled residents. The facility census was 91.1. Review of the facility's Care Planning-Interdisciplinary Team policy, undated, showed the facility Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive plan of care for each resident. 2. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 04/08/26, showed staff assessed the resident with moderate cognitive impairment, did not exhibit behaviors and did not reject care.Review of the resident's care plan, dated 03/02/26, showed the care plan did not contain direction for staff when resident rejects care. Review of the residents' progress notes showed staff documented:-On 02/26/2026 the resident refused to allow staff to change his/her clothing;-On 03/24/2026 the resident refused his/her shower;-On 04/06/26, during a care plan meeting, staff discussed resident required assistance with bathing, dressing, and grooming, but he/she often refused showers and may decline care;-04/14/26, resident refused his/her shower.During an interview on 04/17/26 at 10:21 A.M., Licensed Practical Nurse (LPN) C said the resident frequently refused care. He/She said the resident's care plan should have interventions identified to direct staff related to his/her rejection of care, which is updated by the MDS Coordinator. He/She said he/she did not know if the care plan addressed interventions for rejection of care.During an interview on 04/17/26 at 11:14 A.M., Certified Nurse Aide (CNA) B said if a resident rejects care, staff are directed to reapproach again later, and if still refused, report to the charge nurse. He/She said the resident did have a history of rejecting care, to include showers and facial hair shaving. He/She said the resident's care plan should show interventions for his/her behaviors and his/her rejection of care. He/She said the MDS Coordinator would be responsible for updating the resident's plan of care.During an interview on 04/17/26 at 2:29 P.M., the administrator said the resident had a history of rejecting care. He/She said he/she did not know interventions were not listed in the plan of care.3. Review of Resident #2's quarterly MDS, dated [DATE], showed staff assessed the resident with moderate cognitive impairment and did not exhibit behaviors or reject care.Review of the resident's shower sheet, dated 04/08/26, showed the resident refused his/her shower. Review of the resident's plan of care, dated 02/03/26, showed it did not contain direction for staff when resident rejects care. During an interview on 04/17/26 at 10:56 A.M., Certified Medication Technician (CMT) A said the resident has a history of rejecting care depending on his/her mood. He/She said he/she did not know what the interventions were for the resident when he/she rejects care.During an interview on 04/17/26 at 2:29 P.M., the administrator said the resident has a history of rejecting care and there should be documentation in the care plan the resident rejects care. He/She said he/she could not find documentation in the resident's medical record, other than one incident when resident refused a shower. He/She said he/she did not know interventions were not listed in the plan of care for Resident #2.4. During an interview on 04/17/26 at 10:21 A.M., LPN C said rejection of care should be addressed with interventions in the resident's plan of care. During an interview on 04/17/26 at 2:29 (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	P.M., the administrator said if a resident rejected care, it should be addressed in the resident's care plan with an intervention to guide staff on assisting with behaviors. During an interview on 04/17/26 at 2:29 P.M., the Director of Nursing (DON) said if a resident rejects care, it should be addressed in the resident's care plan with an intervention to guide staff when resident exhibit behaviors. The DON did not say why staff did not update the resident's plan of care to include his/her behaviors and the resident rejects care.During an interview on 04/20/26 at 1:47 PM, the MDS Coordinator said he/she was responsible for updating resident plan of care. He/She said if a resident had exhibited behaviors, it was discussed during the morning meeting, or aide report to him/her if a resident rejected care. He/She said he/she did know Resident #1 rejected care and updated the resident's care plan after the surveyor asked about the resident's history of rejecting care and being addressed in the care plan. He/She said he/she was not told Resident #2 rejected care.#2973742

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview and record review, facility staff failed to maintain professional standards of care when staff left narcotic pain medication unattended at one resident's (Resident #5) bedside and accessible to the resident's roommate. The facility census was 90.1. Review of the facility's Medication Administration policy, dated 02/07/13, showed after staff administer a medication to a resident, staff are to remain in the resident's room while the resident takes the medication. 2. Review of Resident #5's annual Minimal Data Set (MDS), a federally mandated assessment tool, dated 04/11/26, showed the resident's cognition intact, has almost constant pain, and received a scheduled pain medication in the last five days. Review of the resident's care plan, dated 02/28/26, showed the resident resists care which includes taking medications. Review of the resident's physician order sheet, dated January 2026 and March 2026, showed an order for Percocet (A schedule II opioid narcotic prescribed to treat moderate to severe pain) 10-325 milligrams (mg) one tablet every four hours. Review of the resident's medication administration record, dated January 2026 and March 2026, showed the morning dose of Percocet 10-325 mg administered to the resident on 01/06/26 and on 03/21/26. During an interview on 04/29/26 at 12:13 P.M., licensed practical nurse (LPN) C said he/she was the nurse who administered the morning dose of Resident #5's Percocet on 03/21/26. LPN C said he/she went into the resident's room around 7:00 A.M. to administer the Percocet, but the resident was asleep, so he/she left the Percocet on the resident's bedside table. The resident told LPN C he/she woke up and went into the bathroom and when he/she returned, the Percocet was gone. LPN C said he/she knows staff are not supposed to leave medications with residents without watching them take the medication, but they have had issues with the resident become very upset and agitated when staff try to watch him/her take the medications. LPN C said he/she reported the incident to the director of nursing (DON). He/she said the resident does not have orders to leave medications at bedside. During an interview on 04/29/26 at 12:38 P.M., LPN E said he/she was the nurse who administered the morning dose Percocet on 01/06/26. LPN E said he/she went into the resident's room in the morning and left the Percocet with the resident without watching him/her consume the Percocet. The resident told LPN E he/she must have fallen back asleep and when he/she woke up, the Percocet was missing. LPN E said he/she knows staff are not supposed to leave medications with residents without watching them take the medication, and the resident does not have orders to leave medications at bedside, but they have had issues with the resident becoming very agitated when staff tries to watch him/her take the medications and tells staff they are treating him/her like a child. LPN E said he/she reported the incident to the DON. During an interview on 04/29/26 at 12:52 P.M., Registered Nurse (RN) F said he/she was the interim DON in January. RN F said the incident involving the resident Percocet missing on 01/06/26 was reported to him/her. RN F said they have had issues with the resident becoming agitated and yelling at staff when they try to watch him/her take medications, however, staff are expected to stay and watch residents consume the medications and not leave medications with residents. During an interview on 04/29/26 at 1:36 P.M., the interim DON said the incident involving the resident missing Percocet on 03/21/26 was reported to him/her. He/She confirmed the resident has had a pattern of yelling at staff when trying to watch him/her take medications and was aware that LPN C left the Percocet with the resident without watching him/her consume it. He/She said leaving a narcotic medication at bedside is concerning due to him/her having a roommate. The interim DON said he/she always expects staff to stay and watch residents consume their medications and not leave medications with residents. During an interview on 04/29/26 at 1:51 P.M., the administrator said he/she was not aware of the 01/06/26 incident involving the resident missing Percocet and staff leaving it with the resident at bedside, but he/she was aware of the 03/21/26 incident. The administrator said he/she always expects staff to stay and watch residents consume their medications and not leave medications with residents. #2993705

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility staff failed to ensure three residents (Resident #8, #9, and #10) out of three sampled residents, who are dependent for activities of daily living received the necessary services to maintain personal hygiene. The facility census was 91.1.Review of the policies provided by the facility showed the facility did not provide a shower/bathing policy or grooming/hygiene policy. 2. Review of Resident #8's Significant Change Minimum Data Set (MDS), a federally mandated assessment tool, dated 04/06/26, showed staff assessed the resident as: cognitively intact, does not reject care, and is dependent for showers, toileting, dressing and personal hygiene;Review of the care plan, dated 03/05/26, showed staff assessed the resident is unable to bathe self-related to weakness and poor mobility and wishes two showers a week preferably in the mornings. Review showed the resident required one staff for bathing. At times he/she does not want to get up for showers and will request a bed bath. One person for facial hair, use a razor or tweezers to remove hair.Review of the shower schedule undated showed staff documented all showers to be given as scheduled on Wednesdays and Saturdays.Review of the shower sheets, dated March 2026, showed staff documented the resident received a shower on 03/24/26. The staff did not document a shower or refusal for 03/04/26, 03/07/26, 03/11/26, 03/14/26, 03/18/26, 03/21/26, 03/25/26, or 03/28/26.Review of the shower sheets, dated April 2026, showed staff documented the resident received a shower on 04/15/26. The staff did not document a shower or refusal for a shower for 04/01/26, 04/04/26, 04/08/26, 04/11/26, 04/18/26, 04/22/26, 04/25/26, and 04/29/26.Review of the shower sheets, dated May 2026, did not contain staff documentation resident received or refused a shower.Observation on 05/07/26 at 10:36 A.M., showed the resident in his/her wheelchair in an activity. He/She had long facial hair on his/her chin. Observation on 05/07/26 at 11:54 A.M., showed the resident in the lunchroom. He/She had long facial hair on his/her chin. During an interview on 05/07/26 at 11:54 A.M., the resident said he/she can't remember when he/she received a shower last but knows it's been a little while. He/She said it takes two staff to transfer him/her and sometimes there aren't enough staff. He/She said he/she likes to feel clean.3. Review of Resident #9's annual MDS, dated [DATE], showed staff assessed the resident as cognitively impaired, did not exhibit behaviors or reject care, required substantial to maximal assistance by staff for shower/baths.Review of the care plan, dated 03/07/26, showed staff are directed to offer two showers a week, he/she will decline stating does not want to dry skin or because of behaviors staff attempt but may not be able to complete the shower.Review of the shower schedule, undated, showed the resident scheduled to receive a shower on Tuesday and Fridays.Review of the residents shower sheets, dated March 2026, showed staff documented the resident received a shower on 03/24/26. Review showed the shower sheets did not contain staff documentation resident received or refused a shower the rest of March.Review of the residents shower sheets, dated April 2026, showed staff documented the resident received a shower on 04/14/26 and 04/26/26. Review showed the shower sheets did not contain documentation received or refused a shower the rest of April.Review of the residents shower sheets, dated May 2026, showed the shower sheets did not contain documentation resident received or refused a shower in May.Observation on 05/07/26 at 1:34 P.M., showed the resident with a foul odor and had long fingernails.During an interview CNA said the resident oozes bowel movement and often pushes, pulls and hits at staff during care. Sometimes it takes up to five staff to toilet the resident or give a shower. 4. Review of Resident #10's annual MDS, dated [DATE], showed staff assessed the resident as cognitively intact, did not exhibit behaviors or reject care, and required substantial to maximal assistance from staff for showers.Review of the care plan, dated 05/07/26, showed staff are directed resident resists care to include showers, allow resident to choose options, i.e., Would you like to take a shower in the morning or evening?Review of the shower schedule, undated, showed showers are to be given as scheduled on Tuesdays and Fridays.Review of (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the shower sheets, dated May 2026, did not contain documentation resident received or refused a shower in May.Observation on 05/07/26 at 1:02 P.M., showed the resident in bed with dry flaky skin on both legs from the knees to the heels and bright red skin under the abdominal folds and both breasts that were covered with a white cakelike substance and foul smell. During an interview on 05/07/26 at 1:02 P.M., the resident said he/she had not received a shower in three weeks. He/She feels dirty and is embarrassed to get out of bed. He/She said he/she has red, itchy skin under his/her skin folds that smell and would feel better if could get a shower. He/She said when he/she asked about it, he/she is told there is not enough staff but does not make since because other residents are receiving a shower. The only reason his/her hair is clean is because it was washed yesterday in the beauty shop or it would be crusty, dry and itchy. 5. During an interview on 05/07/26 at 1:49 A.M., Nurse Aide (NA) J said he/she is responsible for giving showers and documenting them on a shower sheet. If the resident refuses a shower, then the resident is supposed to sign the shower sheet as refused and gets turned into the Director of Nursing (DON). He/She said the DON put the residents name on the shower sheets and gives it to the bath aide every day for completion. He/She said sometimes the bath aide gets pulled to the floor or has to help with care on the floor and could slow down the showers or they may not get done. He/She said he/she does not know where all the shower sheets are for the residents. The NA said he/she isn't always the bath aide but sometimes the aide on the floor. He/She said shave should be given during showers to all residents including the women. He/She is still in training but has been caring for others all his/her life and knows what to do. During an interview on 05/07/26 at 2:14 P.M., the DON said he/she is responsible to oversee the residents receive showers. He/She fills out the shower sheets for the aides and receives them when the showers are completed. Shaves should be completed during showers. He/She expects if a resident refuses care, staff document it and inform the DON so the DON can speak with the resident. He/She was unaware if the showers were completed for the residents or if they were refused. He/She said refusals and completed care should be documented.#3001687

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review, facility staff failed to ensure residents remained free of significant medication errors when staff administered Resident #3's medication Metformin (medication used to treat type two diabetes by lowering blood sugar levels) and Metorprolol Tartrate (a beta-blocker used to treat high blood pressure, chest pain and heart failure) to Resident #1. The facility census was 91.1. Review of the facility's Medication Administration policy, dated 02/07/13, showed medications are given to benefit a resident's health as ordered by the physician. Introduce yourself, call resident by name, and check picture identification in medication book. Review showed the policy did not contain documentation to direct staff on the five rights of medication administration.2. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 04/08/26, showed staff assessed the resident with moderate cognitive impairment. Review of the facility's Medication Error Documentation form, dated 11/02/25, showed Certified Medication Technician (CMT) A gave Resident #3's medication to Resident #1. Review showed staff documented Resident #1 received Metformin and Metoprolol. Review of Resident #1's Physician Order Summary (POS), dated 04/01/26 through 04/20/26, showed it did not contain a physician's order for Metformin or Metoprolol. During an interview on 4/16/26 at 10:21 A.M., Licensed Practical Nurse (LPN) C said CMT A reported to him/her, he/she administered the wrong medication to the wrong resident. He/She said staff are required to verify they are administering the right medication to the right resident by verifying the name tag on the door, ask the resident his/her name or ask another staff member if unsure. During an interview on 04/16/26 at 2:29 P.M., the administrator said staff were directed to verify the picture in the resident's medical record, the name on the door and ask the resident his/her name or another staff member, to verify the identity of the resident before administering medications. During an interview on 04/16/26 at 2:30 P.M., the Director of Nursing (DON) said staff are educated to verify a resident's identity before administering medication by reviewing the picture in the resident's medical record, observing the name on the door and ask the resident his/her name or another staff member.During an interview on 04/17/26 at 10:56 A.M., CMT A said staff are directed to verify the resident by using the picture in the resident medical record or ask other staff if unsure of the resident's name, before administering medications. He/She said he/she mixed up Resident #1 and Resident #3 when he/she administered Resident #3's medication to Resident #1 and did not identify the residents prior to administering the medications #2973742