

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 04/18/2024
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)		
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37131 Based on observation, interview, and record review, facility staff failed to maintain resident dignity by leaving one resident (Resident #12) exposed to the hallway and failing to properly cover a urinary drainage bag for one resident (Residents #355) of 22 Sampled residents. The facility census was 84. 1. Review of the facilities policies showed the policies did not contain a policy for dignity. 2. Review of Resident #12's Admission Minimum Data Set (MDS), a federally mandated assessment tool, dated 02/28/24, showed staff assessed the resident as follows: -Moderate cognitive impairment; -Required maximal assistance from staff for dressing, personal hygiene and bed mobility; -Dependent on staff for transfers. Review of the resident's care plan, dated 04/15/24, showed staff documented the resident with impulsive behaviors and impaired decision making due to cognitive deficits. Review showed the care plan directs staff to provide assistance of one to two staff members for transfers. Observation on 04/15/24 at 11:58 A.M. showed the door to resident's room and privacy curtain open, with the resident in bed. The resident wore a brief with no other clothes, yelled and appeared non-sensical. The resident could not clearly communicate answers to questions asked of him/her. The resident could be seen from across the hallway. Continued observation showed five staff members walked by the resident's room and did not stop to provide care. Three residents propelled by the resident's door. One resident, Resident #20 stopped and stared in the resident's room at the resident. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/17/24 at 10:39 A.M., Certified Nurse Aide (CNA) J said he/she worked on the resident's hall on 04/15/24. The CNA said he/she went to the resident's room and noticed the resident's gown was off and the privacy curtain had not been pulled. The CNA said he/she could see the resident from the hall. The CNA said he/she would pull the resident's privacy curtain, then would leave and when he/she returned the privacy curtain was back open. The CNA said he/she did not know who had pulled the resident's privacy curtain open, but he/she does not believe the resident can pull the curtain. The CNA said the resident could not get up, or transfer himself/herself to pull the curtain. The CNA said it is an invasion of the resident's privacy. The CNA said the resident constantly undresses himself/herself. The CNA said the charge nurse knows the resident undresses himself/herself. The CNA said staff like to keep the door open so they can see the resident. During an interview on 04/17/24 at 10:47 A.M., Assistant Director of Nursing (ADON) said he/she knew the resident constantly undressed himself/herself and he/she told the aides to keep the door shut. The ADON said he/she would remind staff about pulling the privacy curtain. The ADON said the resident being exposed to hallway is a dignity issue. During an interview on 04/18/24 at 12:48 P.M., the Director of Nursing (DON) said he/she was not familiar with the resident taking his/her clothes off. The DON said he/she would expect staff to watch the resident closely and offer to help the resident put his/her clothes back on, so the resident is not seen undressed from the hallway. The DON said staff can pull the privacy curtain, or close the door, but the DON likes to keep the door open, so if the resident needs anything, staff can hear him/her. The DON said it would be undignified for the resident to be left exposed to the hallway while not dressed. During an interview on 04/18/24 at 1:13 P.M., the administrator said he/she did not know the resident liked to remove his/her clothes. The administrator said staff have the resident's privacy curtain pulled, the blinds closed and close the resident's door, so it is not noticeable. The administrator said it would be a privacy and dignity issue for the resident to be left exposed to the hallway. 3. Review of Resident #355's Quarterly MDS, dated [DATE], showed staff assessed the resident as follows: -Moderate cognitive impairment; -Range of Motion (ROM) impairment to both sides of upper and lower extremities; -Dependent on staff for all Activities of Daily Living (ADL)s; -Has a Urostomy (Creates a stoma for the urinary system. It is made to avail for urinary diversion in cases where drainage of urine through the bladder and urethra is not possible); -Uses a Wheelchair. Review of the resident's care plan dated, 03/10/24, showed staff documented the resident is unable to transfer without assistance and has an Urostomy to divert urine. Review showed the care plan directs staff to keep urinary bag below bladder level and provide assistance with ostomy care. (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 04/15/24 at 12:32 P.M. showed the resident in the dining room with other residents. The resident's urinary catheter bag hung under his/her wheelchair, uncovered. Urine could be seen in the catheter bag across the dining room. Observation on 04/16/24 at 11:52 A.M., showed the resident in the dining room with 27 other residents. The resident's urinary catheter bag hung under his/her wheelchair, uncovered. CNA X and CNA K in the dining room. During an interview on 04/18/24 at 10:30 A.M., CNA K said staff are supposed to put the resident's catheter bag in a privacy bag before the resident leaves the room. The CNA said he/she did not know the resident's catheter bag was not in a privacy bag. During an interview on 04/18/24 at 10:59 A.M., the ADON said staff are supposed to put catheter bags in privacy bag before staff take the resident to the dining room. The ADON said he/she had not noticed staff had not put it in a dignity bag, it is a privacy issue. During an interview on 04/18/24 at 12:48 P.M., the DON said he/she would expect staff to make sure a resident's catheter bag is emptied and covered, before taking the resident to the dining room. During an interview on 04/18/24 at 1:13 P.M., the administrator said he/she expects staff to make sure the resident's catheter bag is emptied, and covered with a dignity bag, before staff take the resident to the dining room.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35558 Based on observation, interview, and record review, facility staff failed to provide a comfortable and homelike environment, when staff failed to ensure resident areas were in good repair and clean. The facility census was 84 with a capacity of 120. Review of the policies provided by the facility showed they did not have a policy for environment, maintenance repairs, and cleaning. 1. Observation on 04/15/24 at 10:01 A.M., showed occupied room [ROOM NUMBER] the wall above the bed with chipped paint. 2. Observation on 04/15/24 at 11:28 A.M., showed occupied room [ROOM NUMBER] walls with multiple large areas gouged. 3. Observation on 04/15/24 at 11:31 A.M., showed occupied room [ROOM NUMBER] with gouged dry wall and missing paint next to the first bed. 4. Observation on 04/15/24 at 11:35 A.M., showed occupied room [ROOM NUMBER] the walls with gouged dry wall and missing paint. The bathroom door gouged, chipped and missing green paint with areas of splintered wood. 5. Observation on 04/15/24 at 11:41 A.M., showed the activity room in the Memory Care Unit with multiple gouges in the dry wall and missing areas of paint on the entry way wall. 6. Observation on 04/15/24 at 11:42 A.M., showed occupied room [ROOM NUMBER] wall with gouges and missing areas of paint beside the beds. 7. Observation on 04/15/24 at 11:44 A.M., showed occupied room [ROOM NUMBER] door with missing wood and and chipped paint. 8. Observation on 04/15/24 at 11:48 A.M., showed occupied room [ROOM NUMBER] wall with damaged drywall and missing paint. 9. Observation on 04/16/24 at 10:28 A.M., showed occupied room [ROOM NUMBER] walls with areas of gouged and missing paint, and a brown substance on the privacy curtain by the window and the mattress. 10. Observation on 04/16/24 at 11:10 A.M., showed occupied room [ROOM NUMBER] the wall by the bed with gouges, scraps, black marks and missing paint. During an interview on 04/18/24 at 10:30 A.M. Certified Nurse Aide (CNA) K said if there is a maintenance issue staff can tell the charge nurse and write it in the maintenance log. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/18/24 at 10:59 A.M., Assistant Director of Nursing (ADON) said if staff notices an issue that needs fixed by maintenance staff are supposed to write the issue down at the nurse's station in the maintenance book. During an interview on 04/18/24 at 1:13 P.M., the administrator said staff should report gouges in the doors and walls to maintenance and write the concern in the maintenance log book. There is a log book at each nurse's station. The administrator said the Maintenance Director should check the maintenance log book daily. The administrator said no one is checking to make sure the Maintenance Director is checking the maintenance log, but he/she will start. During an interview on 04/25/24 at 8:40 A.M., the Maintenance Director said staff should put maintenance concerns in the maintenance log book at the nurse's station. The Maintenance Director said he/she has not received any recent concerns in regard to drywall or paint in resident's rooms. 11. Observation on 04/16/24 at 8:03 A.M., showed a strong persistent odor of urine through the entire 100 hall. Observation on 04/17/24 at 5:29 A.M. through 6:42 A.M., showed a strong persistent odor of urine through the entire 100 hall. observation showed the odor continued until During an interview on 04/17/24 at 6:25 A.M., CNA Q said he/she smelled urine on the 100 hall when he/she walked in at 5:30 A.M. During an interview at 04/17/24 at 8:57 A.M., CNA Q said he/she thinks the urine odor is coming from the carpet. The CNA said there is a resident who urinates on the carpet when he/she stands up. Observation on 04/17/24 at 9:06 A.M., showed a strong odor of urine through out 100 hall and from the carpet inside room [ROOM NUMBER]. During an interview on 04/17/24 at 10:29 A.M., floor technician U said he/she cleans the carpets. The floor technician said he/she did rounds and could smell urine on the 100 hall and in room [ROOM NUMBER], but did not see any wet carpet. The floor technician said staff has not reported to him/her residents urinate on the carpet. The floor technician said he/she can not keep up with cleaning all of the carpets in the facility. The facility has all these carpeted rooms and all the hallways are carpeted and he/she is only one person. During an interview on 04/17/24 at 10:34 A.M., health aide T said he/she smelled urine on the 100 hall and in room [ROOM NUMBER] and told the floor technician. During an interview on 04/17/24 at 11:08 A.M. CNA M said he/she smelled urine on the 100 hall, but certain rooms always smell of urine, because the residents are heavy wetter's. The CNA said sometimes residents will get urine in the carpet. The CNA said he/she did not tell the housekeeper or charge nurse because it slipped his/her mind. Observations on 04/18/24 at 7:20 A.M., 8:43 A.M., 10:21 A.M., 11:48 A.M. and 12:47 P.M., showed the 100 hall had a persistent odor of urine through the entire hallway. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/18/24 at 10:30 A.M., CNA K said he/she noticed the lingering urine odor on the 100 hall. The CNA said the floor technician would clean the carpet and the urine smell would be gone. The CNA said the residents continually make messes on the carpet. The CNA said staff are supposed to let the floor technician know if there is a urine odor coming from resident rooms. During an interview on 04/18/24 at 11:39 A.M., floor technician U said the facility does not have a schedule for cleaning the carpet in resident rooms, hallways or community areas. He/She said he/she cleans the carpets when he/she can. During an interview on 04/18/24 at 11:42 A.M., the housekeeping supervisor said the aides should tell housekeeping if there is a stain on the carpet. The housekeeping supervisor said there is not a schedule for shampooing the carpet, but it is cleaned once a week. During an interview on 04/18/24 at 10:59 A.M., the ADON said he/she knows one resident's room has problems with urine in the carpet. The ADON said if staff know the smell is coming from the carpet, staff should contact housekeeping and the nurse. The ADON said he/she can still smell urine on the hall, it's going to take several extractions, the urine gets under the carpet, on the concrete and there in no getting it out. During an interview on 04/18/24 at 12:48 P.M., the DON said if there is an odor of urine, he/she would expect staff to stop and figure out which room the smell is coming from. The DON said if the urine smell is coming from the carpet staff should notify housekeeping. The DON said he/she had noticed the urine smell on the 100 hall. The DON said he/she really thinks it is the carpet in the resident rooms. The DON said the floors are carpet and hold the smell. During an interview on 04/18/24 at 1:13 P.M., the administrator said he/she would expect staff to have a cleaning schedule for the carpets. 37131 45489		

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35558 Based on interview and record review, facility staff failed to provide written information to the resident and/or the resident's representative of the bed hold policy for five (Residents #18, #19, #23, #340, and #355) of 22 sampled residents. The facility census was 84. 1. Review of the facility's policy titled Bed Hold Guidelines, undated, showed: -The facility will notify all residents and/or their representative of the bed hold guidelines; -This notification shall be given on admission to the facility, at the time of transfer to the hospital, and at the time of non-covered therapeutic leave; -If the resident or resident representative wants to hold the bed, a signed authorization must be obtained with each discharge. 2. Review of Resident #18's medical record showed staff documented the resident had transferred to the hospital on 09/09/23 and returned to the facility on [DATE], and transferred on 3/12/24 and returned to the facility on [DATE]. The resident's medical record did not contain documentation staff notified the resident or the resident's representative of the facility's bed hold policy. 3. Review of Resident #19's medical record showed staff documented the resident transferred to the hospital on 12/28/23 and returned to the facility on [DATE]. The medical record did not contain documentation staff notified the resident or the resident's representative of the facility's bed hold policy. 4. Review of Resident #23's medical record showed staff documented the resident had transferred to the hospital on 11/19/23 and returned to the facility on [DATE]. The medical record did not contain documentation staff notified the resident or the resident's representative of the facility's bed hold policy. 5. Review of Resident #340's medical record showed staff documented the resident had transferred to the hospital on 03/10/24 and returned to the facility on [DATE]. The medical record did not contain documentation staff notified the resident or the resident's representative of the facility's bed hold policy. 6. Review of Resident #355's medical record showed staff documented the resident had transferred to the hospital on the following dates: 09/09/23 and returned to the facility on [DATE]; 11/11/23 and returned to the facility on [DATE], 12/4/23 and returned to facility on 12/08/23. The medical record did not contain documentation staff notified the resident or the resident's representative of the facility's bed hold policy. During an interview on 04/17/24 at 5:19 P.M., the Director of Nursing (DON) said the nurses have not been completing the bed holds. The DON said it is probably because the facility did not have a DON for a couple of years. (continued on next page)		

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/18/24 at 10:59 A.M., the Assistant Director of Nursing (ADON) said the nurse is supposed to fill out the bed hold paperwork. The ADON said he/she has not been filling out the bed hold forms and neither have the other nurses. During an interview on 04/18/24 at 12:48 P.M., the Director of Nursing (DON) said from what he/she can gather, no one fills out the bed hold paperwork, and the nurses are supposed to when the resident discharges to the hospital. During an interview on 04/18/24 at 1:13 P.M., the Administrator said the nurse should fill out the bed hold paperwork, especially on nights when the Social Services Director (SSD) is not here. The administrator said if it is a true emergency staff should call family or send it with the emergency medical staff. He/she does not know why the bed holds were not completed and just found out during the survey when the SSD brought it to his/her attention. 37131 45489		

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35558 Based on interview and record review, facility staff failed to complete the required Minimum Data Set (MDS), a federally mandated resident assessment, within the required timeframe for seven residents (Residents #1, #241, #347, #363, #366, #368 and #376) of 22 sampled residents. The census was 84. 1. Review of the policies provided by the facility showed they did not contain a policy for MDS assessments. Review of the RAI manual 3.0 version 1.18.11, dated October 2023, the RAI-Omnibus Budget Reconciliation Act (OBRA) required Assessment Summary showed assessment time frames as follows: -Quarterly (Non-Comprehensive) MDS completion date not later than ARD + 14 calendar days; -Quarterly assessment for a resident must be completed at least every 92 days following the previous OBRA assessment of any type; 2. Review of Resident #1's Annual MDS, dated [DATE], showed the assessment in process and not submitted in the required time frame. All sections reviewed showed in progress and without information. Review of Resident #241's Annual MDS assessment, dated 03/14/24, showed the assessment in process and not submitted in the required time frame. All sections reviewed showed in progress and without information. Review of Resident #347's Annual MDS assessment, dated 10/10/23, showed the assessment in process and not submitted in the required time frame. All sections reviewed showed in progress and without information. Review of Resident #363's Annual MDS assessment, dated 03/23/23, showed the assessment in process and not submitted in the required time frame. All sections reviewed showed in progress and without information. Review of Resident #366's Annual MDS assessment, dated 02/08/24, showed the assessment in process and not submitted in the required time frame. All sections reviewed showed in progress and without information. Review of Resident #368's Annual MDS assessment, dated 07/17/23, showed the assessment in process and not submitted in the required time frame. All sections showed in progress and without information. Review of Resident #376's Admission MDS assessment, dated 03/39/24, showed the assessment in process and not submitted in the required time frame. All sections reviewed showed in progress and without information. (continued on next page)		

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/16/24 at 2:42 P.M., the MDS Coordinator said he/she spends the majority of his/her time working the floor for call-ins, more so in the last two to three months. The MDS Coordinator said he/she knows the MDS assessments are behind, but he/she is only one person and is not able to get them done. The MDS Coordinator said the Administrator is aware, and he/she believes the Corporate Nurse comes to the facility every couple of weeks to help. The MDS Coordinator also said the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) are both new, and he/she was filling in for those positions before they started. During an interview on 04/16/24 at 2:50 P.M., the administrator said the MDS Coordinator has been frequently working the floor for the last three to four months due to call ins and staff being on medical leave. The administrator said he/she tries to call as needed staff to cover so the MDS Coordinator does not have to. The administrator said he/she knew the facility was behind on completing MDS assessments, and the Corporate MDS Nurse has been coming in to help. He/She said they have not been able to get staff so the MDS coordinator would be able to focus on getting the assessments done. During an interview on 04/18/24 at 12:26 P.M., the MDS Coordinator said the timing according to the Resident Assessment Instrument (RAI) manual, that guides staff in completing MDS assessments, is 14 days for admission assessments and annual assessments are yearly within seven days. The MDS Coordinator said he/she knows there are a lot behind. 37131 45489		

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35558 Based on interview and record review, facility staff failed to ensure Quarterly Minimum Data Set (MDS), a federally mandated assessment tool completed by staff, had been completed no less frequently than once every 92 days as directed by the Resident Assessment Instrument (RAI) manual, manual used for guidance to complete assessments, for nine residents (Resident #4, #14, #19, #22, #30, #347, #363, #368, and #385) of 22 sampled residents. The facility census was 84. 1. Review of the facility policies provided did not contain a policy for MDS assessments. Review of the RAI manual 3.0 version 1.18.11, dated October 2023, the RAI-Omnibus Budget Reconciliation Act (OBRA) required Assessment Summary showed assessment time frames as follows: -Quarterly (Non-Comprehensive) MDS completion date not later than ARD + 14 calendar days; -Quarterly assessment for a resident must be completed at least every 92 days following the previous OBRA assessment of any type. 2. Review of Resident #4's Quarterly MDS assessment, dated 02/04/24, showed the assessment in process and not submitted in the required time frame. All sections reviewed showed in progress and without information. 3. Review of Resident #14's Quarterly MDS assessment, dated 05/10/23, showed the assessment in process and not submitted in the required time frame. All sections reviewed showed in progress and without information. 4. Review of Resident #19's Quarterly MDS assessment, dated 02/06/24, showed the assessment in process and not submitted in the required time frame. All sections reviewed showed in progress and without information. 5. Review of Resident #22's medical record showed a Quarterly MDS, dated [DATE], did not have further MDS assessments completed. 6. Review of Resident #30's Quarterly MDS assessment, dated 02/09/24, showed the assessment in process and not submitted in the required time frame. All sections reviewed showed in progress and without information. 7. Review of Resident #347's medical record showed an Annual MDS, dated [DATE], in process and not submitted. Review showed staff did not complete quarterly assessments had been completed since the 10/10/23 annual assessment. 8. Review of Resident #363's Quarterly MDS assessment, dated 03/22/24, showed the assessment in process and not submitted in the required time frame. All sections reviewed showed in progress and without information. (continued on next page)		

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. Review of Resident #368's Quarterly MDS assessment, dated 07/17/23, showed the assessment in process and not submitted in the required time frame. All sections reviewed showed in progress and without information. 10. Review of Resident #385's Quarterly MDS assessment, dated 03/05/24, showed the assessment in process and not submitted in the required time frame. All sections reviewed shower in progress and without information. During an interview on 04/16/24 at 2:42 P.M., the MDS Coordinator said he/she spends the majority of his/her time working the floor for call-ins in the last couple of months. The MDS Coordinator said he/she knows the MDS assessments are behind, but he/she is one person and is not able to get them done. The MDS Coordinator said the administrator is aware and he/she believes the corporate nurse comes to the facility every couple of weeks to help. The MDS Coordinator said the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) are both new and he/she had to fill in for the positions before they started. During an interview on 04/16/24 at 2:50 P.M., the Administrator said the MDS Coordinator has been frequently working the floor for the last three to four months due to call ins and staff being on medical leave. The administrator said he/she tries to call as needed (PRN) staff to cover so the MDS Coordinator does not have to. The administrator did know the facility was behind on completing MDS assessments, and the Corporate MDS Nurse has been coming in to help. We have not been able to get staff to allow MDS to be able to focus on getting the assessments done. 37131 45489		

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35558 Based on interview and record review, the facility failed to encode resident assessment data within seven days after a facility completed a resident's assessment and transmit the assessment timely for fourteen residents (Residents #1, #4, #14, #19, #30, #239, #241, #340, #363, #366, #368, #376, #383, and #385) of 22 sampled residents. The census was 84. 1. Review of the Minimum Data Set (MDS, a federal mandated assessment instrument completed by facility staff) version 3.0 Resident Assessment Instrument (RAI) user manual, showed: -For all non-admission assessments, the MDS completion date must be no later than 14 days after the Assessment Reference Date (ARD); -For the admission assessment, the MDS completion date must be no later than 13 days after the entry date; -Encoding data: Within seven days after completing a resident's MDS assessment or tracking record, the provider must encode the MDS data (i.e., enter the information into the facility MDS software). 1. Review of Resident #1's Annual MDS assessment, dated 02/08/24, showed the assessment in process and not submitted in the required time frame. 2. Review of Resident #4's Quarterly MDS, dated [DATE], showed the assessment in process and not submitted in the required time frame. 3. Review of Resident #14's medical record showed a Discharge MDS assessment, undated and Quarterly MDS assessment, dated 05/10/23, in process and not submitted in the required time frame. 4. Review of Resident #19's Quarterly MDS, dated [DATE], showed the assessment in process and not submitted in the required time frame. 5. Review of Resident #30's Quarterly MDS, dated [DATE], showed the assessment in process and not submitted in the required time frame. 6. Review of Resident #239's medical record showed a Quarterly MDS assessment, dated 11/04/23, and Annual MDS assessment, dated 02/04/24, in process and not submitted in the required time frame. 7. Review of Resident #241's Annual MDS assessment, dated 03/14/24, showed the assessment in process and not submitted in the required time frame. 8. Review of Resident #340's medical record showed two Admission MDS assessments, dated 01/09/24 and 03/22/24, in process and not submitted in the required time frame. 9. Review of Resident #363's medical record showed an Annual MDS, dated [DATE] and a Quarterly MDS assessment, dated 03/22/24, in process and not submitted in the required time frame. (continued on next page)		

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10. Review of Resident #366's Annual MDS assessment, dated 02/08/24, showed the assessment in process and not submitted in the required time frame. 11. Review of Resident #368's medical record showed an Annual MDS assessment and a Quarterly MDS assessment, dated 07/17/23, in process and not submitted in the required time frame. 12. Review of Resident #376's Admission MDS assessment, dated 03/29/24, showed the assessment in process and not submitted in the required time frame. 13. Review of Resident #383's Admission MDS assessment, dated 04/08/24, showed the assessment in process and not submitted in the required time frame. 14. Review of Resident #385's medical record showed an Annual MDS assessment, dated 09/04/23, and a Quarterly MDS assessment, dated 03/05/24, in process and not submitted in the required time frame. During an interview on 04/16/24 at 2:42 P.M., the MDS Coordinator said he/she spends the majority of his/her time working the floor for call-ins in the last couple of months. The MDS Coordinator said he/she knows the MDS assessments are behind, but he/she is one person and is not able to get them done. The MDS Coordinator said the administrator is aware, and he/she believes the Corporate Nurse comes to the facility every couple of weeks to help. The MDS Coordinator said the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) are both new, and he/she had to fill in for the positions before they started. During an interview on 04/16/24 at 2:50 P.M., the administrator said the MDS Coordinator has been frequently working the floor for the last three to four months due to call ins and staff being on medical leave. The Administrator said he/she tries to call as needed staff to cover so the MDS Coordinator does not have to. The administrator did know the facility was behind on completing MDS assessments, and the Corporate MDS Nurse has been coming in to help. We have not been able to get staff to allow MDS to be able to focus on getting the assessments done. During an interview on 04/18/24 at 12:26 P.M., the MDS Coordinator said he/she knows there are a lot behind. 37131 45489		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37131 Based on record review and interview, facility staff failed to complete a baseline care plan within 48 hours of admission for three residents (Resident #33, #36, and #383) out 22 sampled residents. The facility census was 84. 1. Review of the facility's policy titled Care Plan, Temporary, dated March 2015, showed: -A temporary care plan will be implemented to meet the new resident's immediate needs; -To assure that the resident's immediate care needs are met and maintained, a temporary care plan will be implemented for the resident within twenty-four hours of admission; -The temporary care plan will be used until the comprehensive assessment has been completed and an interdisciplinary care plan has been developed according to the Resident Assessment Instrument (RAI) process. 2. Review of Resident #33's medical record showed staff documented the resident was admitted to the facility on [DATE]. The record did not contain a baseline care plan. 3. Review of Resident #36's medical record showed staff documented the resident was admitted to the facility on [DATE]. The record did not contain a baseline care plan. 4. Review of Resident #383's medical record showed staff documented the resident was admitted to the facility on [DATE]. The record did not contain a baseline care plan. During an interview on 04/17/24 at 3:59 P.M., the Director of Nursing (DON) said if there is not a baseline care plan in the system there probably is not one. During an interview on 04/18/24 at 10:59 A.M., the Assistant Director of Nursing (ADON) said the admitting nurse completes the baseline care plan, and he/she did not know how long they had to complete it. The ADON said staff are not completing the baseline care plans, and there is no excuse for it. The ADON said he/she spends more time on the floor as a floor nurse than he/she does doing his/her ADON job. During an interview on 04/18/24 at 1:13 P.M., the administrator said the nurses start the baseline care plans and the Minimum Data Set (MDS) Coordinator finishes them. They have 24 to 48 hours to complete there and he/she does not know why the baseline care plans are not getting done. The administrator said there were MDS and care plan issues before he/she started at the facility, but staff will be educated. 45489		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37131 Based on observation, interview and record review, facility staff failed to develop and implement a comprehensive person-centered care plan for seven residents (Resident #3, #18, #22, #33, #241, #340, and #376) out of 22 sampled residents. The facility census was 84. 1. Review of the facility's policy titled, Care Plan Comprehensive, dated March 2015, showed staff were directed as follows: -An individualized comprehensive care plan that includes measurable goals and time frames will be developed to meet the resident's highest practicable physical, mental, and psychosocial well-being; -The interdisciplinary care plan team with input from the resident, family, and/or legal representative will develop and maintain a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain; -The comprehensive care plan will be based on a thorough assessment that includes but is not limited to the Minimum Data Set (MDS - a federally mandated assessment tool); -A well developed care plan will be oriented to respecting the resident's right to decline treatment, offering alternative treatments, addressing additional care planning areas that are relevant to meeting the resident's needs in the long-term care setting; -The resident's comprehensive care plan is developed within seven days of the completion of the resident's comprehensive assessment. 2. Review of Resident #3's Admission MDS, dated [DATE], showed staff assessed the resident as follows: -Required moderate assistance from staff with bathing, dressing lower body, put on/take off footwear and personal hygiene; -Required supervision or touch assist from staff for bathing and bed to chair transfers. Review of the resident's comprehensive care plan, dated 03/26/24, did not contain documentation of the residents interventions for Activities of Daily Living (ADLs). During an interview on 04/18/24 at 10:30 A.M., certified nurse aide (CNA) K said the amount of care a resident required should be care planned. During an interview on 04/18/24 at 10:59 A.M., Assistant Director of Nursing (ADON) said a resident's ADLs should be care planned. During an interview on 04/18/24 at 12:48 P.M., the Director of Nursing (DON) said a resident's ADLs should be care planned. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/18/24 at 1:13 P.M., the administrator said a resident's ADLs should be care planned. 3. Review of Resident #18's Quarterly MDS, dated [DATE], showed staff assessed the resident as follows: -Intact cognition; -Required supervision or touch assist from staff for toileting hygiene, upper body dressing and toilet transfers; -Required moderate assist from staff for bathing, lower body dressing and personal hygiene; -Occasionally incontinent of bowel and bladder. Review of the resident's comprehensive care plan, dated 03/10/24, showed it did not contain the assistance the resident required for ADLs and incontinence care. Observation on 04/17/24 at 9:08 A.M., showed the resident told the Floor Technician U his/her bed is wet all the way down to the sheets. CNA Q pulled back the resident's cover and sheet to show the bed almost completely covered in urine. During an interview on 04/17/24 at 9:13 A.M., CNA Q said the resident is incontinent when he/she stands up from bed and urine goes in the carpet. During an interview on 04/18/24 at 10:30 A.M., CNA K said incontinence care should be care planned. During an interview on 04/18/24 at 10:59 A.M., ADON said if a resident has incontinence it should be care planned. During an interview on 04/18/24 at 12:48 P.M., the DON said he/she would expect incontinence to be care planned. During an interview on 04/18/24 at 1:13 P.M., the administrator said he/she would expect incontinence to be care planned. 4. Review of Resident #22's Quarterly MDS, dated [DATE], showed staff assessed the resident as follows: -Severe cognitive impairment; -Dependent on staff for eating; -Coughing or choking during meals, or when swallowing medications. Review of the resident's comprehensive care plan, dated 04/15/24, did not contain direction for staff to ensure the resident's bed is at 45 degree angle when eating and after eating due to aspiration risk. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 04/15/24 at 12:55 P.M., showed the ADON fed the resident in a Broda chair angled at 15 degrees. The ADON left the room with the resident at a 15 degree angle. During an interview on 04/15/24 at 3:04 P.M., the ADON said he/she fed the resident. The ADON said the resident is at risk for choking and aspiration and should be kept at a 45 degree angle during meals and for 45 minutes after. The ADON said he/she does not remember the resident being below a 45 degree angle. During an interview on 04/18/24 at 10:30 A.M., CNA K said the resident is at risk for choking. Staff should keep the resident up in the chair or keep the head of the bed up at least 45 degrees at all times. The CNA said he/she is not comfortable laying the resident flat at all. The CNA said it should be care planned. During an interview on 04/18/24 at 10:59 A.M., the ADON said the resident's intervention of being at a 45 degree angle when eating and for 30 minutes after eating should be care planned. The ADON said the resident is at risk of choking and aspirating. During an interview on 04/18/24 at 12:48 P.M., the DON said he/she expects staff to ensure the resident's chair is at a 45 degree angle or more when the resident is eating. The DON said he/she expects staff to leave the back of the chair up for an hour or so after the resident eats, to make sure the food stays down. The DON said he/she would expect those interventions and choking risk to be on the resident's care plan. During an interview on 04/18/24 at 1:13 P.M., the administrator said the resident is a choking and aspiration risk. The administrator said he/she would expect staff to ensure the head of the resident's bed and chair are elevated during meals, and it should remain elevated for at least 30 minutes after meals. The administrator said it should be care planned. 5. Review of Resident #33's Admission MDS, dated [DATE], showed staff assessed the resident as follows: -Severe cognitive impairment; -Dependent on staff for eating, oral hygiene, toileting, shower/bathe self, lower body dressing, and personal hygiene; -Received a mechanically altered diet (a diet that modifies texture to make food easier to chew and swallow); -Has broken or loosely fitting or partial dentures; and obvious or likely cavity or broken natural teeth; -At risk for pressure ulcers (injury to skin and underlying tissue resulting from prolonged pressure on the skin); -Receives antianxiety, antidepressant, anticoagulant, and antiplatelet medications; (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses of high blood pressure, blood clot, Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), dementia with agitation, depression, dysphagia (difficulty swallowing), and seizures; -Section V Care Area Assessment summary indicated the following should be care planned: Cognitive Loss/Dementia; Communication; Activities of Daily Living (ADLs) - Functional/Rehabilitation Potential; Urinary Incontinence and Indwelling Catheter; Behavioral Symptoms; Falls; Nutritional Status; Dental Care; Pressure Ulcer; and Psychotropic Drug Use. Review of the resident's comprehensive care plan, dated 03/13/24, showed it did not contain direction for staff in regard to the resident's communication, ADLs, urinary incontinence, behavioral symptoms, nutritional status, dental care, pressure ulcers, and psychotropic drug use. Observation on 04/15/24 at 12:13 P.M., showed the resident with unshaved facial hair. Observation on 04/15/24 at 3:08 P.M., showed the resident with food stains on his/her shirt and pants. During an interview on 04/18/24 at 10:30 A.M., CNA K said the resident's facial hair preferences should be care planned. The CNA said the resident's should be shaved during showers. During an interview on 04/18/24 at 10:59 A.M., the ADON said residents' facial hair preferences and care required should be care planned. During an interview on 04/18/24 at 12:26 P.M., the MDS Coordinator said he/she is responsible for care plans and would expect behaviors, dementia/cognitive loss, and psychotropic medication use to be on the care plan. The MDS Coordinator said he/she knows the care plans are not comprehensive. The DON has been trying to help by educating staff they can add to the care plans. During an interview on 04/18/24 at 12:35 P.M., the ADON said he/she would expect to see psychotropic medication use, behaviors, and dementia on the care plan, as it is part of their diagnoses and should be on there so we know how to care for the residents. During an interview on 04/18/24 at 12:48 P.M., the DON said he/she has never put facial hair preferences on a care plan, but it should probably be done. During an interview on 04/18/24 at 1:13 P.M., the administrator said facial hair preferences should be on the care plan for all residents and should be completed as needed and during showers. The Administrator said he/she would expect to see all care areas addressed on the care plan, and the MDS Coordinator is responsible for getting it done. 6. Review of Resident #241's Quarterly MDS, dated [DATE], showed staff assessed the resident as follows: -Moderate cognitive impairment; -Required substantial/maximum assistance for toileting and shower/bathe self; (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Did not document assistance required for personal hygiene; -Diagnoses of Alzheimer's Disease, dementia with agitation, Parkinson's Disease (a chronic brain disorder that causes involuntary movements, such as shaking, stiffness, and difficulty with balance); Lewy body dementia (a form of progressive dementia that affects a person's ability to think, reason, and process information), Obsessive Compulsive Disorder ((OCD) excessive thoughts that lead to repetitive behaviors), and anxiety. Review of the resident's comprehensive care plan, dated 04/05/24, showed it did not contain the resident's ADL assistance needs for showering and shaving, and did not contain facial hair preferences. Observation on 04/15/24 at 11:50 A.M., showed the resident in the memory care unit dining room with unshaven facial hair. Observation on 04/15/24 at 3:08 P.M., showed the resident in the memory care unit activity area with unshaven facial hair. During an interview on 04/15/24 at 12:31 P.M., the resident's spouse said the resident likes to be clean shaven and likes to have clean clothes. The resident has OCD and can become upset when not clean shaven. During an interview on 04/16/24 at 8:11 A.M., the resident said Monday was supposed to be shower day, can I get a shower today?, and he/she would like to be shaved. During an interview on 04/18/24 at 10:30 A.M., CNA K said the resident's facial hair preferences should be care planned. CNA K said the resident's should be shaved during showers, and no resident should have facial hair if they do not want it. During an interview on 04/18/24 at 10:59 A.M., the ADON said residents' facial hair preferences should be care planned. During an interview on 04/18/24 at 12:48 P.M., the DON said he/she has never put facial hair preferences on a care plan, but it should probably be done. During an interview on 04/18/24 at 1:13 P.M., the Administrator said facial hair preferences should be on the care plan for all residents and should be completed as needed and during showers. 7. Review of Resident #340's medical record showed: -admitted to facility on 12/30/23; -Diagnoses of showed of Parkinson's Disease, anxiety, dementia, depression, and insomnia; -Did not contain a completed MDS assessments. Review of the resident's Physician Order Sheet (POS) showed: (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Lorazepam (anxiety medication) 0.25 milliliters (ml) by mouth every four hours as needed for anxiety; -Sertraline (antidepressant medication) 100 milligrams (mg) daily for depression; -Trazodone (antidepressant medication) 300 mg at bedtime for insomnia. Review of the resident's care plan, dated 04/15/24, showed it did not contain direction for staff in regard to the resident's cognitive loss/dementia, behavioral needs, and psychotropic medication use. During an interview on 04/18/24 at 12:26 P.M., the MDS Coordinator said he/she is responsible for care plans and would expect behaviors, dementia/cognitive loss, and psychotropic medication use to be on the care plan. The MDS Coordinator said he/she know the care plans are not comprehensive. The DON has been trying to help by educating staff they can update the care plans. During an interview on 04/18/24 at 12:33 P.M., Licensed Practical Nurse (LPN) V said cognitive loss/dementia, behaviors and psychotropic medication use should be on the care plan. LPN V said the MDS Coordinator is responsible for completing the care plans. LPN V said he/she recently started at the facility and he/she did not know if he/she could add to the care plans. During an interview on 04/18/24 at 12:35 P.M., the ADON said he/she would expect to see psychotropic medication use, behaviors, and dementia on the care plan, as it is part of their diagnosis and needs to be on there so staff know how to care for the residents. During an interview on 04/18/24 at 1:13 P.M., the Administrator said he/she would expect to see all care areas addressed on the care plan, and the MDS Coordinator is responsible for getting it done. The Administrator said he/she knew there was an issue with care plans and MDS before you guys came, and there will be education for nurses to let them know they can add to them. The Administrator said the MDS Coordinator has been working the floor as charge nurse due to staffing calling in and has not been able to get them done. 8. Review of Resident #376's MDS medical record showed: -admitted to facility on 03/21/24; -Did not contain any completed MDS assessments. Review of the resident's care plan, dated 03/21/24, showed it did not contain direction for staff in regard to the resident's facial hair preferences. Observation on 04/15/24 at 12:20 P.M., showed the resident with multiple long hairs on his/her chin and greasy uncombed hair. Observation on 04/16/24 at 10:22 A.M., showed the resident with multiple long hair on his/her chin and greasy uncombed hair. (continued on next page)		

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 04/17/24 at 8:07 A.M., showed the resident with multiple long hairs on his/her chin and greasy uncombed hair. Observation on 04/18/24 at 7:48 A.M., showed the resident with multiple long hairs on his/her chin, an greasy uncombed hair. During an interview on 04/17/24 at 8:07 A.M., the resident said he/she does not like having long facial hair. The resident said he/she would trim the hair at home with scissors, but staff does not do it like they should here. The resident said it is overdue to be shaved. During an interview on 04/18/24 at 10:30 A.M., Certified Nurses Aide (CNA) K said the resident's facial hair preferences should be care planned, but staff should shave the residents with showers. During an interview on 04/18/24 at 10:59 A.M., the Assistant Director of Nursing (ADON) said residents' facial hair preferences should be care planned. During an interview on 04/18/24 at 12:48 P.M., the DON said he/she honestly has never put facial hair preferences on a care plan, but it should probably be done. During an interview on 04/18/24 at 1:13 P.M., the administrator said facial hair preferences should be on the care plan for men and women and should be done as needed and during showers. 9. During an interview on 04/18/24 at 12:26 P.M., the MDS Coordinator said he/she is responsible for care plans and would expect to see any resident preferences on the care plan such as facial hair, wake up time preferences, whatever makes it feel more like home. The MDS Coordinator also would expect behaviors, dementia/cognitive loss, activities of daily living, and psychotropic medication use to be on the care plan. The MDS Coordinator said he/she knew the care plans were not comprehensive, and the DON has been educating staff on how they can add to the care plan. 45489		

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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** 35558 Based on observation, interview and record review, facility staff failed to ensure residents that were unable to complete their own activities of daily living (ADL), received the necessary care and services to maintain good personal hygiene when staff failed to ensure residents remained clean, dry and free from odor for three residents (Residents #10, #18, and #347) and failed to provide hair care to two residents (Resident #376, and #383) of 22 sampled residents. The facility census was 84. 1. Review of facility's policy titled, Activities of Daily Living (ADL), dated March 2015, showed: -Purpose is to assist resident in achieving maximum function; -Gives step-by-step guidance with dressing residents. Review of the facility's policy titled, Shaving the Resident, dated March 2015, showed: -Purpose is to remove facial hair and improve the resident's appearance and morale; -Gives step-by-step guidance with shaving residents, does not address the frequency or preferences. Review of the facility's policy titled, Bath (Shower), dated March 2015, showed: -Purpose is to maintain skin integrity, comfort and cleanliness; -Gives step-by-step guidance with bathing residents, does not address the frequency or preferences. Review of the policies provided by the facility showed they did not have a policy for incontinence care for residents. 2. Review of Resident #10's Significant Change in Status (SCSA) Minimum Data Set (MDS), a federally mandated assessment tool, dated 03/11/24, showed staff assessed the resident as: -Severe cognitive impairment; -Impairment to both lower extremities; -Dependent on staff for personal hygiene and toileting; -Always incontinent of bowel and bladder; -Diagnosis of Dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities). Review of the resident's care plan, dated 03/07/24, showed staff are directed to provide incontinence care frequently throughout the day. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 04/17/24 at 6:39 A.M., showed the resident in bed with a strong fecal odor. Observation on 04/17/24 08:02 A.M., showed the resident lay in bed covered in feces. An unknown staff member covered the resident up and did not change him/her. Observation on 04/17/24 at 08:36 A.M., showed an unknown staff entered the resident's room, sat a drink down on the table and did not check the resident. Observation on 04/17/24 at 08:39 A.M., showed the same unknown staff entered the resident's room and did not check the resident. Observation on 04/17/24 from 09:03 A.M., to 10:25 A.M., showed the resident in bed covered in feces. Observation on 04/17/24 at 10:25 A.M., showed Certified Nurse Aide (CNA) H provided incontinence care for the resident. During an interview on 04/17/24 at 10:25 A.M., CNA H said the resident had a large amount of dried feces on his/her bottom. The CNA said the resident required full assistance and should be checked every two hours. 3. Review of Resident #18's Quarterly MDS, dated [DATE], showed staff assessed the resident as follows: -Cognitively intact; -Did not reject care; -Required supervision or touch assistance from staff for toileting hygiene, upper body dressing and toilet transfers; -Required moderate assistance from staff for bathing, lower body dressing and personal hygiene; -Occasionally incontinent of bowel and bladder. Review of the resident's care plan, dated 03/10/24, showed it did not contain direction for staff in regard to incontinence care for the resident. Observation on 04/17/24 at 5:32 A.M., showed a strong odor of urine around the resident. Observation on 04/17/24 at 5:56 A.M. showed a strong odor of urine continued from around the resident. Observation on 04/17/24 at 6:04 A.M., showed Nurse Aide (NA) P entered the resident's room and came back out of the room at 6:07 A.M. The resident remained in bed and continued to have a strong odor of urine around him/her. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 04/17/24 at 06:10 A.M., showed a strong odor of urine around the resident. The odor could be smelt down the hall. Observation on 04/17/24 at 6:18 A.M., showed CNA M passed the resident's doorway four times and did not stop to check where the odor came from. During an interview on 04/17/24 at 6:35 A.M., NA P said he/she did not smell anything coming from the resident when he/she went in the resident's room. Observation on 04/17/24 at 8:04 A.M., showed a strong odor of urine in the hallway outside the resident's room. The resident in bed with a strong odor of urine around him/her. Observation on 04/17/24 at 8:06 A.M., showed CNA M went into the resident's room to retrieve a breakfast tray. The CNA exited the room and went to the next room. The CNA did not provide care to the resident. Observation on 04/17/24 at 8:49 A.M., Licensed Practical Nurse (LPN) S entered the resident's room to provide care to the resident's roommate and did not assist the resident. Observation showed a strong odor of urine in the room. Observation on 04/17/24 at 8:51 A.M., the Director of Nursing (DON) walked down the hall passed the resident's door to the hall. Urine can still be smelled in hall outside the resident's room. Observation on 04/17/24 at 9:08 A.M., showed the resident told Floor Technician U his/her whole bed is wet, all the way down to the sheets. CNA Q pulled back the resident's blanket and dry sheet and revealed a mattress heavily saturated in urine. During an interview on 04/17/24 at 9:13 A.M., CNA Q said the night shift aide NA P put clean sheets over the resident's wet pad and soiled sheet. The CNA said he/she received report from NA P and he/she said he/she changed the resident. The CNA said the resident's brief is dry, so NA P had to change the resident's brief and put a clean sheet and blanket over a soiled pad and sheet, because it is all wet with urine. During an interview on 04/17/24 at 11:08 A.M., CNA M said he/she smelled urine but some resident rooms smell like urine, because the resident's are heavy wetters. The CNA said NA P said he/she changed the resident. During an interview on 04/18/24 at 10:59 A.M., the Assistant Director of Nursing (ADON) said staff should provide incontinence care every two hours and as needed. The ADON said if staff smell urine, staff should investigate and take care of it at that time. During an interview on 04/18/24 at 12:48 P.M., the DON said staff should provide incontinence care every two hours. The DON said if a resident is dry, but the urine smell is still there, he/she would expect staff to figure out where the urine smell was coming from. The DON said staff should never put a clean dry sheet over a soiled sheet. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/18/24 at 1:13 P.M., the administrator said staff should provide incontinence care every two hours and as needed. The administrator said staff should not put clean sheets over dirty sheets. The administrator said staff should remove the soiled sheets and disinfect the mattress. The administrator said if staff smell urine in hallway, staff should figure out where the urine smell is coming from. 4. Review of Resident #347's Quarterly MDS, dated [DATE], showed staff assessed the resident as follows: -Moderate cognitive impairment; -Did not reject care; -Required maximal assist from staff for bed mobility, transfers, bathing and toilet hygiene; -Frequently incontinent of bladder. Review of the resident's care plan, dated 04/05/24, showed staff documented resident has poor bladder control. The care plan directs staff to provide incontinence care after each incontinent episode and keep skin as clean and dry as possible, to minimize exposure to moisture. Observation on 04/17/24 at 5:32 A.M., showed the resident in bed with a strong urine odor. The urine could be smelt outside the resident's room. Observation on 04/17/24 at 5:56 A.M. showed a strong odor of urine around the resident. Observation on 04/17/24 at 6:04 A.M., showed Nurse Aide NA P entered the resident's room and exited the room at 6:07 A.M. The resident continues to have a strong odor of urine around him/her while in bed. Observation on 04/17/24 at 06:10 A.M., showed a strong odor of urine continued around the resident. Observation on 04/17/24 at 6:18 A.M., showed CNA M walked by the resident's doorway four times and did not stop and check for the source of the urine odor. Observation on 04/17/24 at 6:21 A.M., CNA Q passed the resident's room four times and did not stop to check for the source of the urine odor on the hallway. The fifth time CNA Q walked by he/she entered the resident's room and provided incontinence care for the resident. During an interview on 04/17/24 at 6:25 A.M., CNA Q said he/she smelled urine on the resident's hall when he/she first walked on the hall. CNA Q said CNA M told him/her the overnight aides did their last rounds, but CNA Q had not double checked the residents yet. CNA Q said NA P did not tell him/her any residents needed changed. The CNA said if staff smells urine, they should find out where it is coming from. The CNA said the resident was wet when he/she checked him/her. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/17/24 at 6:35 A.M., NA P said he/she did not smell anything coming from the resident. The NA then said, I'm not gonna lie, when I felt him/her, he/she was wet. The NA said he/she was going to come back to change him/her. During an interview on 04/17/24 at 11:08 A.M., CNA M said he/she smelled urine, but certain rooms on the resident's hall always smell of urine. The CNA said the rooms smell of urine because the residents are heavy wetters. CNA M said he/she did not report the urine odor to the charge nurse. The CNA said NA P said he/she changed the resident. During an interview on 04/18/24 at 10:59 A.M., the ADON said staff should provide incontinence care every two hour and as needed. The ADON said if staff smell urine on the hall, they should find out the source and take care of it at that time. During an interview on 04/18/24 at 12:48 P.M., the DON said staff should provide incontinence care every two hours. The DON said he/she would expect staff to stop and figure out which room the urine smell was coming from and provide care for the resident. During an interview on 04/18/24 at 1:13 P.M., the administrator said staff should provide incontinence care every two hours and as needed. The administrator said if staff smell urine in the hallway, staff should find the source and clean it up. 5. Review of Resident #376's medical record showed it did not contain a completed comprehensive MDS assessment. The resident admitted to the facility on [DATE] with diagnoses of Alzheimer's disease, high blood pressure, heart failure, and dementia. Review of the resident's care plan, dated 04/02/24, showed staff documented: -Refuses to take showers through the week; -If resident refused, attempt to find out why and see if it can be solved so they can take a shower; -Required assistance from one staff for bathing, grooming, and to have personal care needs met while supporting strengths and personal goals; -Did not address the resident's facial hair preference. Review of the resident's medical record showed it did not contain documentation staff provided the resident a shower or resident refusal of care. Observation on 04/15/24 at 12:20 P.M., showed the resident with greasy uncombed hair, and multiple inch long hairs on his/her chin. Observation on 04/16/24 at 10:22 A.M., showed the resident with uncombed hair and multiple inch long hairs on his/her chin. Observation on 04/16/24 at 2:23 P.M., showed the resident with multiple inch long hairs on his/her chin. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 04/17/24 at 8:07 A.M., showed the resident with greasy uncombed hair, and multiple inch long hairs on his/her chin. Observation on 04/18/24 at 7:48 A.M., showed the resident with greasy uncombed hair, and multiple inch long hairs on his/her chin. During an interview on 04/17/24 at 8:07 A.M., the resident said he/she does not like having long facial hair, and he/she would trim it at home with scissors. The resident said they do not do it like they should here, and he/she is overdue for a shave. During an interview on 04/18/24 at 10:53 A.M., CNA L said he/she noticed the long hair on Resident #376 and he/she needs to get a razor and shave him/her, but it has been a bit hectic. The CNA said he/she is normally by himself/herself and it has been non-stop call lights and he/she has not had time to get to it. During an interview on 04/18/24 at 10:30 A.M., CNA K said the resident's facial hair preferences should be care planned. The CNA said residents should be shaved during showers. During an interview on 04/18/24 at 10:59 A.M., the ADON said the residents' ADL's should be care planned. The ADON said how are staff supposed to do their jobs if ADL's are not care planned. 6. Review of Resident #383's medical record it did not contain a completed MDS assessment. The resident admitted to the facility on [DATE], with diagnose of vascular dementia. Review of the resident's care plan, dated 4/17/24, directed staff as follows: -Required extensive assistance with bathing, dressing and mobility. -Required assistance to have personal care needs met; -Did not address the resident's facial hair preference. Observation on 04/15/24 at 12:06 P.M., showed the resident wore a night gown in the dining room. The resident had thick chin hairs. Observation on 04/16/24 at 11:09 A.M. and 2:25 P.M., showed the resident with long hair on his/her chin. Observation on 04/17/24 at 7:45 A.M., showed the resident with long hair on his/her chin. Observation on 04/18/24 at 9:57 A.M., showed the resident with greasy uncombed hair and long hairs on his/her chin. During an interview on 04/15/24 at 12:11 P.M., the resident's family member said the chin hair should not be there, it grows fast, but he/she would have never let it grow out in the community. During an interview on 04/16/24 at 11:09 A.M., the resident said he/she would like help with shaving and he/she needs to be shaved. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/18/24 at 10:53 A.M., CNA L said it is a little hard to get anything done with the resident. The CNA said he/she is normally by himself/herself and it has been non-stop call lights and have not had time to get to it. During an interview on 04/18/24 at 10:56 A.M., LPN V said the resident has long facial and he/she does not know why. The LPN said staff should shave the hairs during the resident's shower. During an interview on 04/18/24 at 10:59 A.M., the ADON said residents' ADL's should be care planned. 7. During an interview on 04/18/24 at 12:48 P.M., the DON said some of the residents receive showers regularly, some are able to shower themselves, and some are not being done on a regular basis. The DON said some are not getting done due to not having a shower schedule for staff to follow. The shower sheets should be filled out completely, including refusals. The DON said staff should try again if a resident refuses to take a shower or shave. Facial hair should be shaved during every shower, and more frequently if needed. The DON said it is his/her responsibility to ensure showers and shaves are completed. During an interview on 04/18/24 at 1:13 P.M., the Administrator said residents receive showers at least twice a week, and as needed. Staff should fill out the shower sheets so the charge nurses and DON can review for any skin issues or concerns. The Administrator said it is probably due to staffing that showers are not getting completed, but staffing is getting better. The Administrator said the DON and charge nurses are responsible for making sure showers are completed. The Administrator said facial hair should be shaved during showers and as needed. 37131 45489		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38417 Based on observation, interview, and record review, facility staff failed to lock the medication and treatment carts, and failed to store medications and chemicals in a safe manner. The facility census was 84 with a capacity of 120. 1. Review of the facility's policy titled Storage of Medication, dated March 2015, showed staff were directed to: -All medications must be stored at or near the nurse's station in a locked cabinet, a locked medicine room, or one or more locked mobile carts; -All mobile medication carts must be under visual control of the staff at all times when not stored safely and securely; -All poisonous substances and other hazardous compounds, such as sterilization solutions, irrigation solutions, antiseptics, diagnostic agents, etc must be kept in a locked container; -An unattended medication cart must remain locked at all times, the cart must be locked before leaving it or secured in a locked medication room. 2. Observation on 04/15/24 at 11:12 A.M., showed the 100 hall treatment cart unlocked and unattended in the hall with multiple residents nearby. The 100 hall treatment cart contained multiple treatments, and three tubes of an antifungal medication. Observation on 04/15/24 at 11:26 A.M., showed the southwest treatment cart unlocked and unattended with a bottle of wound cleanser on top of the cart and multiple residents nearby. Observation on 04/15/24 at 2:43 P.M., showed the 100 hall treatment cart sat unlocked and unattended as a resident walked by. Observation on 04/15/24 at 2:44 P.M., showed the southwest treatment cart sat by resident room [ROOM NUMBER] unlocked and unattended with two residents nearby. Observation on 04/15/24 at 2:46 P.M., showed the southwest medication cart sat by resident room [ROOM NUMBER] unlocked and unattended. During an interview on 04/15/24 at 2:47 P.M., Licensed Practical Nurse (LPN) V said he/she should not have left his/her medication cart unlocked or unattended in the hall. LPN V said he/she heard a resident yell and he/she responded without thinking about locking the cart. Observation on 04/15/24 at 2:48 A.M., showed LPN V left a box of 12 insulin pens unlocked and unattended on top of his/her medication cart in the hall while he/she administered insulin to a resident in their room. LPN V returned to the medication cart and put the resident's two insulin pens in the box the left the box of 14 insulin pens unlocked and unattended on his/her cart again. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 04/15/24 at 2:58 P.M., showed LPN V left a box of 14 insulin pens on top of his/her cart unlocked and unattended in the hall with residents nearby. During an interview on 04/15/24 at 2:58 P.M., LPN V returned to his/her cart and said he/she should not have left the insulin pens unlocked and unattended on top of the cart. He/She said the pens should be locked up for resident safety. Observation on 04/15/24 at 3:00 P.M., showed LPN V left a box of 13 insulin pens unlocked and unattended on top of his/her medication cart in the hall while he/she gave a resident insulin in their room. Observation on 04/16/24 at 10:27 A.M., showed the southwest hall crash cart unlocked and unattended with a bottle of wound cleaner in the second drawer. Observation on 04/17/24 at 7:35 A.M., showed the southwest medication cart in the hall near resident room [ROOM NUMBER] with a card of 30 Lisinopril (medication used to treat high blood pressure) on top of the cart unattended. During an interview on 04/17/24 at 7:37 A.M., Certified Medication Technician (CMT) CC said the card of Lisinopril should not have been left on top of the unlocked and unattended on medication cart. Observation on 04/17/24 at 9:00 A.M., showed the southwest crash cart unlocked and unattended with a bottle of wound cleanser in the second drawer. Observation on 04/17/24 at 2:17 P.M., showed the 100 hall nurse medication cart unlocked and unattended at the nurses station with multiple residents nearby. Observation on 04/17/24 at 4:27 P.M., showed the 100 hall nurse medication cart unlocked and unattended with a bottle of an antifungal medication powder. Observation on 04/17/24 at 4:27 P.M., showed the 100 hall treatment cart with three bottles of wound cleanser in the side bin of the cart unattended. Observation on 04/18/24 at 7:12 A.M., showed the 100 hall treatment cart with three bottles of wound cleanser in the side bin of the cart unattended. Observation on 04/18/24 at 8:45 A.M., showed the southwest hall treatment cart sat with unlocked and unattended with a bottle of wound cleanser on top of it and residents nearby. Observation on 04/18/24 at 8:46 A.M., showed the southwest crash cart unlocked and unattended with a bottle of wound cleaner in the second drawer. During an interview on 04/17/24 at 2:22 P.M., the Assistant Director of Nursing (ADON) said medication and treatment carts should be kept locked, and medications should not be on top of the cart when unattended. He/She said this is prevent anyone from getting into the cart and for resident safety. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/18/24 at 10:10 A.M., LPN V said medication and treatment carts should never be left unlocked or unattended and medications should not be left on top of the cart. He/She said anyone, including staff, visitors, or residents could get in the cart or take a medication. LPN V said this could potentially cause a resident harm. During an interview on 04/18/24 at 10:35 A.M., CMT AA said medications should not be left on top of the cart, and all carts should be locked when staff are not using them. Medication and treatment carts should never be left unlocked and unattended for resident safety. During an interview on 04/18/24 at 11:20 A.M., the Director of Nursing (DON) said staff should never leave the treatment or medication carts unlocked or unattended, and medications should never be left on top of the carts as a resident can get them and cause them harm. During an interview on 04/18/24 at 1:13 P.M., the administrator said medications are not to be left out unattended on top of the cart. He/She said the treatment carts and medication carts are not to be left unlocked an unattended. He/She said anyone can get the medications if they are unlocked and unattended and a resident could potentially ingest them and be harmed.		

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. 48982 Based on interview and record review, facility failed to ensure two Nurse Aides ((NA) NA DD and NA P) of three sampled staff completed the nurse aide training program within four months of employment in the facility. The facility census was 84. 1. Review of the facilities policies did not contain a policy for NA training or qualifications. Review of NA DD's personnel file showed a hire date of 05/18/23. The file did not contain documentation NA DD completed the nurse aide training program. Review of NA P's personnel file showed a hire date of 08/28/23. The file did not contain documentation NA P completed the nurse aide training program. Review of the facility's payroll, dated April 2024, showed NA DD and NA P worked at the facility as NA's. During an interview on 04/16/24 at 2:16 P.M., the administrator said he/she did not know the facility had two NA's who were not compliant with training. The administrator said the Minimum Data Set (MDS) Coordinator schedules and monitors the NA's online classes. During an interview on 04/16/24 at 2:25 P.M., the MDS Coordinator said he/she did not know the facility had two NA's who were not compliant with training. The MDS Coordinator said he/she took over scheduling and monitoring of the NA's online classes a couple of months ago and he/she did not have a tracking system in place to monitor the employee's date of hire, date they began classes, or when they finish the class to ensure it is completed within 120 days. During an interview on 04/18/24 at 11:20 A.M., the Director of Nursing (DON) said he/she did not know the employees were not in compliance with training requirements. The DON said he/she started at the facility about a month ago and he/she has not looked at the NA compliance dates.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48982 Based on observation, interview, and record review, facility staff failed to maintain a medication error rate less than five percent (%) out of 29 opportunities observed, six errors occurred which resulted in a 20.7% error rate which effected four residents (Resident #15, #18, #23, and #347) of the six sampled residents. The facility census was 84. 1. Review of the facility's policy titled Medications, Errors and Drug Reactions, dated March 2015, showed staff were directed to: -Report all medication errors and drug reactions immediately to the physician, Director of Nursing (DON), and administrator; -Provide emergency care to the resident; -Follow physician's orders; -Complete event report; -Chart in the resident's clinical record. Review of the manufacturer's recommendations for Kwik-Pens (ightweight pen that's prefilled with insulin), dated 10/18/15, showed staff were directed to: -Prime the pen before each injection; -To prime the pen turn the dose knob to two units; -Hold the pen with the needle pointing up, tap the cartridge holder gently to collect air bubbles at the top; -Push the knob until it stops at zero. 2. Review of Resident #23's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 11/24/23, showed staff assessed the resident as cognitively intact. Review of the resident's Electronic Medication Administration Record (e-MAR), dated 04/15/24, showed a physician's order directed staff to administer: -Lispro insulin (a rapid acting medication to lower blood sugar) 20 Units (U) with meals; -Lantus insulin (a long-acting medication to lower blood sugar) 30 U two times a day. Observation on 04/15/24 at 2:48 P.M., showed Licensed Practical Nurse (LPN) V administered the resident's insulins via insulin pens and did not prime the insulin pen prior to administration. (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of Resident #15's Quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively intact. Review of the resident's e-MAR, dated 04/15/24, showed a physician's order directed staff to administer Novolog insulin (a rapid acting medication used to lower blood sugar) 6 U per sliding scale for a blood sugar of 262. Observation on 04/15/24 at 3:00 P.M., showed LPN V administered the resident's insulin via an insulin pen and did not prime the needle of the pen prior to administration. During an interview on 04/18/24 at 10:10 A.M., LPN V said he/she only primes new insulin pens and did not know he/she should prime the pen with each dose given. The LPN said the insulin pen could get air in it and it is important to remove the air. He/She said if the air is not removed it can cause the resident to get the wrong dose and this would be considered a medication error. 4. Review of Resident #15's e-MAR, dated 04/16/24, showed a physician's order directed staff to administer Levimer insulin (a long-acting medication to lower blood sugar) 15 U daily. Observation on 04/15/24 at 3:00 P.M., showed the Assistant Director of Nursing (ADON) administered the resident's insulin via an insulin pen and did not prime the needle prior to administration. 5. Review of Resident #18's Quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively intact. Review of the resident's e-MAR, dated 04/16/24, showed a physician's order directed staff to administer Lantus 15 U daily and Lispro 8 U per sliding scale for a blood sugar of 345. Observation on 04/15/24 at 3:00 P.M., showed the ADON administered the resident's insulins via an insulin pen and did not prime the needle prior to administration. During an interview on 04/17/24 at 2:22 P.M., the ADON said staff should prime the insulin pen with one unit of insulin before each administration. The ADON said this ensures the resident gets the correct dose as air bubbles can get in the pen. The ADON said if staff does not prime the pen each time it can result in the resident getting the wrong dose and would be a medication error. 6. During an interview on 04/18/24 at 11:20 A.M., the DON said insulin pens should be primed with two units of insulin before each use. The DON said this is to get any air bubbles out that may be in the pen and ensure the resident gets the correct dose. If an insulin pen is not primed each time staff use it this is a medication error. During an interview on 04/18/24 at 1:13 P.M., the administrator said insulin pens should be primed with two units before each use. This is done in case there is an air bubble in the pen and ensures the resident gets the complete ordered dose. The administrator said if staff do not prime insulin pens it would be a medication error.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48982 Based on observation, record review, and interview the facility staff failed to count narcotic medications each shift for three of three medication cart, failed to reconcile one resident's (Resident #242) liquid lorazepam (narcotic antianxiety medication) of 84 sampled residents, failed to separate treatments in one treatment cart of one sampled cart, failed to date medications when opened for ten residents (Resident #238, #240, #18, #351, #21, #27, #348, #345, #350) out of 84 sampled residents. The facility census was 84. 1. Review of the facility's policy titled Narcotic Count, dated March 2015, showed staff were directed to: -Complete a physical inventory of narcotics at each shift change to identify discrepancies; -One Registered Nurse (RN), Licensed Practical Nurse (LPN), or Certified Medication Technician (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 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 must be retained for one year; -After the supply is counted and justified, the nurse/CMT records the date and his/her signature verifying the count is correct. 2. Review of the narcotic substance shift change logs, dated March 2024, showed: -Memory Care Unit (MCU) narcotic substance shift change log did not contain completed shift counts; -100 and 200 hall narcotic substance shift change log did not contain completed shift counts. Review of the narcotic substance shift change logs, dated April 2024, showed the MCU, 100 hall and 200 hall narcotic substance shift change logs did not contain completed shift counts. Observation on 04/17/24 at 7:30 A.M., showed staff did not complete a narcotic count at shift change. During an interview on 04/17/24 at 7:37 A.M., CMT CC said he/she did not complete his/her narcotic count at the change of shift because the off going nurse was busy. CMT CC said he/she accepted the keys and started his/her medication pass without doing the narcotic counts. CMT CC said he/she should have counted with the off going nurse to ensure there were no medication discrepancies. 3. Review of Resident #242's lorazepam (to relieve anxiety) 2 milligrams per milliliter (mg/ml) narcotic count sheet, dated 02/16/24, showed staff documented 22.5 milliliters (ml) of lorazepam remained in the vial. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 4/15/24 at 11:44 A.M., showed the resident's bottle of lorazepam contained 16 ml remained, 6.5 ml difference than the narcotic count sheet. During an interview on 04/15/24 at 11:44 A.M., LPN V said he/she did not count the liquid narcotics with the off going nurse when he/she came on duty. LPN V said he/she will report to the DON the discrepancy found in the lorazepam immediately. The LPN said it is his/her second day at the facility and he/she did not know what to do. During an interview on 04/17/24 at 2:22 P.M., the Assistant Director of Nursing (ADON) said narcotics should be counted at the beginning of each shift and the end of each shift with the off-going and on-coming nurse or CMT. The ADON said two staff should count the narcotics together. It is the responsibility of the ADON and the DON to monitor and ensure the narcotic counts are being completed. The ADON said when staff administers a narcotic they should sign it out on the narcotic log immediately. The ADON said as far as he/she knows the narcotic counts are being completed and if they are not, they should be. The ADON said he/she does narcotic counts each shift but forgets to sign the book. He/She said if something is not documented it is not done. During an interview on 04/18/24 at 10:10 A.M., LPN V said narcotics should be counted each shift by the off going licensed staff and the on-coming licensed staff to ensure when the on-coming staff accept the keys to the cart that the count is correct. LPN V said staff should sign narcotics out when they are administering them on the resident's narcotic sheet to prevent discrepancies. LPN V said he/she noticed most staff do not count the controlled liquid medications. LPN V said if staff does not count the narcotics and accepts the keys to the cart, they are still responsible for the medications in the cart and any discrepancy that may occur. During an interview on 04/18/24 at 10:35 A.M., CMT AA said staff should count narcotics at shift change. The CMT said the off going nurse and on-coming staff should count together and prior to the on-coming person accepting the keys to the cart. CMT AA said once the person accepts the keys to the cart the medications and any discrepancies are their responsibility. CMT AA said any discrepancies should be reported to the DON or ADON immediately. He/She said staff should sign out any narcotics as they are administered. During an interview on 04/18/24 at 11:20 A.M., the Director of Nursing (DON) said LPN V informed him/her about the resident's liquid lorazepam. The DON said he/she instructed LPN V to check each individual dose to ensure it was recorded on the narcotic count sheet to see if he/she can locate the missing doses. The DON said licensed staff are expected to count narcotics with every shift change and if someone must leave early. The DON said the off going licensed person must count with the on coming licensed person to ensure there are no discrepancies in the narcotic counts prior to accepting the keys to the cart. If a person accepts the keys to the cart, they are responsible for it and anything missing that may arise. The DON said staff should sign out on the narcotic count sheet any narcotic they administer at the time they give the medication. He/She said if something is not documented then it did not happen. Should report a discrepancy immediately. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/18/24 at 1:13 P.M., the Administrator said he/she was not made aware of the discrepancy found with Resident #242's liquid Lorazepam. The Administrator said if staff find a discrepancy, they are to report it to the Administrator, DON, and physician immediately. He/She said an investigation is to be done once the discrepancy is found. The Administrator said he/she expects narcotics to be counted each shift by the off going licensed person and the oncoming licensed person before the keys are accepted by the oncoming person. The Administrator said it is the responsibility of the DON to monitor narcotic count logs to ensure they are being completed. 5. Review of the facility's policy titled, Storage of Medications, dated March 2015, showed drugs must be stored in an orderly manner in cabinets, drawers, or carts and each resident must have a space assigned to them that prevents the possibility of a drug for one resident to be administered to another. 6. Observation on 04/15/24 at 11:12 A.M., showed the 100 hall treatment cart contained multiple treatments not separated by resident. The 100 hall treatment cart contained three tubes of an antifungal medication opened but did not contain a date or resident name. 6. Observation on 04/15/24 at 11:27 A.M., showed the southwest medication room refrigerator contained open vials of influenza vaccine and Tuberculosis ((TB) indicated to aide diagnosis of TB) solution. The vials did not contain dates of when opened. Observation on 04/15/24 at 11:44 A.M., showed the southwest medication cart contained: -One loose brown round pill in the top left drawer; -Albuterol inhaler with Resident #238's name on the box, opened and not dated; -Atropine (medication to treat eye conditions) eye drops with Resident #240's name on the bottle, opened and not dated; -One loose white round pill in the narcotic drawer. Observation on 04/15/24 at 12:04 P.M., showed the 100 hall nurse medication cart contained the following: -One Lidocaine (topical anesthetic) vial open and not dated; -Insulin (medication used to control blood sugar) pen with Resident #18's name on it, opened and not dated; -Insulin pen with Resident #351's name on it, opened and not dated; -Insulin pen with Resident #21's name on it, opened and not dated; -Haldol (medication used to treat nervous, emotional, and mental conditions) vial with Resident #27's name on it, opened and not dated; -Assorted trash in the second drawer; (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-51 loose pills in the second drawer. Observation on 04/15/24 at 12:27 P.M., showed the 100 hall CMT medication cart contained the following: -Albuterol inhaler with Resident #348's name on the box, opened and not dated; -Albuterol inhaler with Resident #345's name on the box, opened and not dated; -Albuterol inhaler with Resident #351's name on the box, opened and not dated; -A cup of five loose pills in the top drawer did not contain a date or resident's name; -Two loose white round pill in the third drawer. During an interview on 04/15/24 at 12:27 P.M., CMT CC said the cup of pills belonged to Resident #350 who refused to take them earlier. CMT CC said he/she was going to attempt to administer them again at this time. During an interview on 04/17/24 at 2:22 P.M., the ADON said it is the responsibility of the staff member who opens a medication to date it. The ADON said it is the responsibility of all the staff who pass medication to keep the carts clean. The ADON said there should not be loose pills or trash in the drawers of the cart. The ADON said treatments should be separated in a bag or bin per each resident individually to prevent cross contamination. The ADON said all staff who use the treatment cart should ensure treatments are separated. During an interview on 04/18/24 at 10:10 A.M., LPN V said if a staff member opens a medication, they are responsible to date it. The LPN said all eye drops, inhalers, nasal sprays, vials such as Tuberculosis (TB) solution, flu vaccines, insulin, and stock treatment creams should all be dated when opened. It is the responsibility of all the licensed staff who use the medication carts and treatment carts to keep them clean. The medication cart should not have trash or loose pills in the drawers. LPN V said treatment carts are to be separated and each resident should have their medications in their own bag to prevent cross contamination. During an interview on 04/18/24 at 10:35 A.M., CMT AA said if staff open a medication, it is their responsibility to date it. CMT AA said the medication carts should be kept clean and not have trash or loose pills in the drawers. It is the responsibility of the staff working on the cart to keep it clean. During an interview on 04/18/24 at 11:20 A.M., the DON said if a staff member opens a medication such as stock creams, TB solution, insulin, flu vaccine, eye drops, inhaler, or nasal spray they are responsible to date it. He/She said the treatment carts are to be separated by residents and each resident should have a bag or a bin to individually to prevent cross contamination. The DON said it is the responsibility of the staff using the cart to keep it clean and there should be no trash or loose pills in the drawers. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/18/24 at 1:13 P.M., the administrator said any staff who open a new medication are to date it. The administrator said treatment carts should have treatments separated per resident to prevent cross contamination. All carts are to be kept clean, should not have trash or loose pills in them, and it is the responsibility of all the staff working with the cart to keep it clean. 50432		

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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. 33477 Based on observation, interview and record review, the facility staff failed to store food in a manner to prevent potential contamination and out-dated use. Facility staff failed to maintain the mechanical dishwasher in good repair to ensure dishes were effectively washed and sanitized to prevent cross-contamination. Facility staff failed to allow cleansed dishes to air-dry prior to stacking in storage to prevent the growth of food-borne pathogens. Facility staff failed to maintain the ice machine in a sanitary manner to prevent cross-contamination. Facility staff failed to maintain the kitchen equipment and surfaces in a sanitary manner to prevent the growth of bacteria and cross-contamination. Facility staff also failed to perform hand hygiene as often as necessary to prevent cross-contamination. These failures have the potential to affect all residents. The facility census was 84. 1. Review of the facility's Receiving and Storage of Food policy, dated April 2011, showed: -The Dining Services Manager is responsible for receiving and storing food and nonfood items; -Follow the rule of First In, First Out (FIFO); -Keep all foods in clean, undamaged wrappers or packages. Reseal open boxes effectively; -Keep storage areas clean and dry. Review of the facility's Storage of Dry Food and Supplies policy, dated April 2011, showed: -The dietary department will store dry food and supplies according to facility guidelines and state regulation; -The storeroom must be neat and orderly. Shelving is kept clean and free of rust and chipped paint; -Metal or plastic containers with tight fitting covers, labeled top or side, must be used for storing opened products; -Only National Sanitation Foundation (NSF) approved storage containers and food grade vinyl bags are used for food storage; -Open boxes are to be effectively re-sealed. Bulk crackers, cereal, cookies, pasta, et cetera (etc.) are to be stored and properly labeled in sealed containers. Food-grade plastic bags are to be tightly closed after being opened. Observations on 04/15/24 at 10:19 A.M., showed the dry goods storage pantry contained: -An opened and undated 50 pound bag of granulated sugar stored inside an undated plastic barrel. Observation showed the lid to the barrel cracked which exposed the contents to the air and a measured drink pitcher buried in the sugar inside the bag; (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Loose oatmeal, removed from its original packaging, stored in side an undated plastic barrel lined with a white plastic bag; -A large undated plastic container labeled pureed bread mix that contained pureed bread mix removed from it's original container; -An opened and undated 50 pound bag of brown sugar stored inside an undated plastic barrel; -An opened and undated 25 pound bag of flour and an opened 25 pound bag of fish breeding with a stock date of 04/19 and no opened date; -An opened 10 pound bag of spiral noodles with a stock date of 08/14 and no opened date; -An opened five pound bag of egg noodles with a stock date of 09/20 and no opened date.; -An undated 22 quart plastic container labeled food thickener that contained food thickener removed from its original packaging; -An undated 22 quart container labeled powdered milk that contained powdered milk removed from its original packaging; -A six pound eight ounce can of spaghetti sauce, a 28 ounce can of diced pimentos, and a five pound 13 ounce can of spinach with dents on the seams of the cans stored on the can storage rack. Observation on 04/15/24 at 10:36 A.M., showed two undated metal sheet pans of sausage stored in the walk-in refrigerator. Observation on 04/16/24 at 10:27 A.M., showed the dry goods storage pantry contained: -An opened and undated 50 pound bag of granulated sugar stored inside an undated plastic barrel. Observation showed the lid to the barrel cracked which exposed the contents to the air and a measured drink pitcher buried in the sugar inside the bag; -Loose oatmeal, removed from its original packaging, stored in side an undated plastic barrel lined with a white plastic bag; -A large undated plastic container labeled pureed bread mix that contained pureed bread mix removed from it's original container; -An opened and undated 50 pound bag of brown sugar stored inside an undated plastic barrel; -An opened and undated 25 pound bag of flour and an opened 25 pound bag of fish breeding with a stock date of 04/19 and no opened date; -An opened 10 pound bag of spiral noodles with a stock date of 08/14 and no opened date; -An opened five pound bag of egg noodles with a stock date of 09/20 and no opened date.; (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-An undated factory prepared graham cracker crust stored on the bottom shelf with its cover loosened which exposed the crust to the air; -An opened 24 oz bag of crispy fried onions with a stock date of 08/14 and no opened date; -An opened 25 pound box of parboiled rice with a stock date of 03/21 and no opened date and a second opened 25 pound boxes of perfect parboiled rice opened to the air. Once dated 3/21 and other dated 4/10; -An undated 22 quart plastic container labeled food thickener that contained food thickener removed from its original packaging; -an undated 22 quart container labeled powdered milk that contained powdered milk removed from its original packaging; -A five pound 13 ounce can of spinach with two dents on the seam of the can stored on the can storage rack. Observation showed an accumulation of dust and debris on the rungs of the can storage rack; During an interview on 04/16/24 at 10:38 A.M., Cook F said the white plastic bags used to line the bulk food barrels were regular trash bags. During an interview on 04/16/24 at 12:45 P.M., the Dietary Manager (DM) said the white plastic bags used to line the bulk food barrels were regular trash bags and the bags were not food-grade. The DM said he/she did not know that food products removed from their original packages, like the loose oats, needed to be stored in food-grade bags or containers. The DM also said the bags of food items inside the bulk food item barrels should be rolled shut to keep them fresh and prevent things from getting into them and staff should not leave scoops inside the bulk food items. The DM said staff are trained on these requirements. Observation on 04/16/24 at 12:47 P.M., showed the box of white plastic bags, identified by the DM as the bags used to line the bulk food barrels, did not identify the bags as food-grade or NSF approved for food storage. Observation on 04/16/24 at 1:56 P.M., showed opened and undated plastic bags of diced chicken and pork riblette patties stored in the walk-in freezer. Observation on 04/16/24 at 2:00 P.M., showed an opened and undated five pound container of creamy peanut butter stored on the shelf by the food preparation sink. Observation showed peanut butter residue around the exterior of the container. Observation on 04/17/24 at 9:24 A.M., showed an opened and undated five pound container of creamy peanut butter stored on the shelf by the food preparation sink. Observation showed peanut butter residue around the exterior of the container. Observation on 04/17/24 at 9:43 A.M., showed opened and undated plastic bags of diced chicken and pork riblette patties stored in the walk-in freezer. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview 04/17/24 10:25 A.M., the DM said opened food items should be dated when opened so that the food items should have two dates on them; the stock date and the opened date, and staff should use all of one container before they open another so that the oldest food is used first. The DM said dented cans should be stored in his/her office and not with the in-use food supply. The DM said opened food items should also be stored in a way that they are sealed air tight and if a food storage container is damaged staff should throw it away and not use it to store food. The DM said he/she did not know lid to sugar container was cracked. The DM said staff should also clean the outside of containers if they have food on them. The DM said he/she has repeatedly in-serviced the staff on food storage requirements. During an interview 04/17/24 at 11:25 A.M., the administrator said opened food items should be stored dated and sealed in approved containers and if a food storage container is damaged staff should get rid of it and not use it for food storage. The administrator said staff should clean food residue off of the exterior of food containers, scoops should not be left inside containers of food, staff should not use trash bags for food storage and dented cans should be removed from the in-use supply to be sent back to the supplier. The administrator said staff are trained on proper food storage procedures and the DM is responsible to monitor the food storage regularly. 2. Review of the facility's Dishmachine policy, dated April 2011, showed the washing temperature of the dishmachine is to be 150 degrees and the final rinse is to be 180 degrees, except on a low temperature machine in which an adequate temperature is a minimum of 120 degrees, and this should be noted prior to washing the morning dishes and a test strip should be used and noted. Review of the facility's Dishwashing policy, dated April 2011, showed the policy directed staff to: -Fill the dishmachine with water and turn on heaters according to manufacturer instructions; -Check chemical dispensers for proper operation and adequate supply of chemical; -Record temperature of wash and rinse cycle three times daily on heat sanitized machines and one time daily on chemical sanitized machines. Review of the manufacturer's installation records for the facility's low-energy dishmachine, undated, showed: -Water heaters or boilers must provide the minimum temperature required by the type of machine and a minimum recovery rate of 82 gallons per hour. The recommended temperature range for optimal performance is 130 to 140 degrees Fahrenheit (dF). Minimum water temperature is 120 dF; -Set sanitizer concentrations at 50 parts per million (ppm). Warning: Do not exceed 100 PPM's; -Monitor chlorine levels by using chlorine test strips. Observation on 04/15/24 at 9:56 A.M., showed four baking sheets stacked together on the storage rack in the kitchen. Observation showed one of the baking sheets had multiple areas of dried meat product on it and the other three had sticky dried food around their edges. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 04/15/24 at 10:10 A.M., showed dietary staff washed soiled dishes in the mechanical dishwasher. Observation during the second consecutive run of the dishwasher, the gauge on the dishwasher registered the water temperature of the wash cycle at 102 dF and the water temperature of the rinse cycle measured 118 dF. Observation of the manufacturer's instruction label on the dishwasher showed direction for the minimum water temperature to be 120 dF and the sanitizer concentration to be at 50 ppm of available chlorine rinse. During an interview on 04/15/24 at 10:12 A.M. the dietary manager (DM) said the water temperature for the wash and rinse cycles of the dishwasher should be 120 dF. The DM said he/she knew the water in the dishwasher did not get enough and it did not get hot enough because one of the three facility water heaters did not work. The DM said the maintenance director knew about the water temperature problem. Observation on 04/16/24 at 11:03 A.M., showed Dietary Aide (DA) B washed soiled dishes in the mechanical dishwasher. Observation showed a sodium hydrochloride (chlorine) sanitizer used in the dishwasher. Observation showed the concentration of the chlorine sanitizer used in the dishwasher measured 200 ppm when tested with a chlorine sanitizer test kit. Observation also showed the gauge on the dishwasher registered the water temperature of the wash cycle at 108 dF and the water temperature of the rinse cycle at 116 dF. Review of the facility's Dish Machine Temperature Log, dated April 2024, showed staff documented the sanitizer concentration at 200 ppm three times a day for the dates of 04/01/24 through 04/14/24, at breakfast and lunch on 04/15/24 and at breakfast on 04/16/24. Review showed staff did not record the dishwasher's water temperature or sanitizer concentration at dinner on 04/15/24. Review also showed staff documented water temperatures below 120 dF as follows: -04/06/24 Breakfast: Wash 100 dF and Rinse 118 dF; -04/06/24 Lunch: Wash 100 dF and Rinse 118 dF; -04/07/24 Breakfast: Wash 100 dF and Rinse 110 dF; -04/07/24 Lunch: Wash 100 dF and Rinse 100 dF; -04/13/24 Breakfast: Wash 100 dF and Rinse 115 dF; -04/13/24 Lunch: Wash 100 dF and Rinse 100 dF; -04/15/24 Breakfast: Wash 120 dF and Rinse 115 dF; -04/15/24 Lunch: Wash 120 dF and Rinse 113 dF; -04/16/24 Breakfast: Wash 119 dF and Rinse 116 dF. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 04/16/24 at 11:12 A.M., the DM said he/she knew the water in the dishwasher did not get enough, but it was hotter at breakfast time than rest of day. The DM said they got a booster heater for the dishwasher after the previous survey, but that did not really help and they have continued to have problems with the water not getting hot enough. The DM said he/she most recently told the maintenance director again about the water not getting hot enough about two weeks ago and again on 04/15/24, but he/she did not write the problem in the maintenance log as he/she is supposed to do when something needs repaired. The DM said, while he/she knew the water did not get hot enough, the dishwasher service provider said it was a low-temperature machine and he/she thought water temperatures of 115 to 116 dF were normal. The DM said he/she did not know the water temperature needed to be at least 120 dF. the DM said he/she had not read the manufacturer's instructions for the machine or the manufacturer's label on the dishwasher and thought it was okay for the sanitizer concentration to be 200 ppm okay. The DM said staff should not use dishwasher if it did not working right and it was his/her fault that they still washed dishes in the machine, because he/she did not tell staff not to use it. During an interview on 04/16/24 at 11:18 A.M., the maintenance director said the dietary manager did not report any issues with the dishwasher water temperature to him/her until yesterday. The maintenance director said if something needs repaired, staff are supposed to notify him/her by writing it down in the maintenance log book and the issue had not been documented in the log book. Observation on 04/16/24 at 11:36 A.M., showed when tested with a calibrated metal stem-type thermometer, the water temperature of the dishwasher wash cycle measured 94 dF and the gauge on the dishwasher registered the water temperature at 94 dF. Observation showed when tested with a calibrated metal stem-type thermometer, the water temperature of the subsequent rinse cycle measured 106 dF and the gauge on the dishwasher registered the water temperature at 106 dF. During an interview on 04/17/24 11:33 AM, the administrator said dietary staff are to monitor the dishwasher for proper working condition daily and if it is not working appropriately, then staff should notify maintenance in writing and not use the dishwasher until it is fixed. The administrator said he/she did not know about the issues with the dishwasher. 3. Review of the facility's Dishmachine policy, dated April 2011, showed the policy directed staff to allow dishes to air dry after they are washed and stack in proper area. Review of the facility's Dishwashing policy, dated April 2011, showed the policy directed staff to allow dishes to thoroughly dry before unloading racks or storing items. Observation on 04/15/24 at 9:59 A.M., showed five of eight large white bowls and two of two metal food preparation and service pans stacked together wet on the dish storage racks. Observation on 04/17/24 at 9:16 A.M., showed 15 of 15 large white bowls stacked together wet upside down on storage rack across from steamtable. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 04/17/24 from 9:25 A.M. to 9:27 A.M., showed DA A, a removed a rack of cleansed dishes from the mechanical dishwasher and used a towel to dry the inside of insulated bowls before he/she put them away. Observation showed the DA stacked a large white bowl while wet on top of a stack of large white bowls on the storage shelf by the steamtable. Observation showed the DA also removed a rack of cleansed service trays from the mechanical dishwasher, stacked them together while wet and put them on the storage shelf. During an interview on 04/17/24 at 9:28 A.M., DA A said staff trained him/her to allow dishes to air dry before they are put away and he/she did not have a reason as to why he/she did not let them dry before he/she put them away. Observation on 04/17/24 at 9:39 A.M., showed the DM stacked together multiple cleansed service trays from the clean side of the mechanical dishwashing station while wet and put them on the storage shelf. During an interview on 04/17/24 at 9:42 A.M., the DM said dishes should be air dried before they are put away and he/she did not look at the trays to see if they were dry before he/she put them away. The DM said staff are trained to allow dishes to air dry and they should not use a towel to dry the dishes. Staff should also check to make sure the dishes are clean before they are put away. Staff also trained on this. During an interview on 04/17/24 at 11:33 A.M., the administrator said dietary staff should allow dishes to air dry completely before they are put away, staff should not use a towel to dry dishes and the staff are trained on proper dishwashing and storage requirements. 4. Review of the facility's Cleaning Guidelines-Ice Machine policy, dated March 2015, showed Ice may be come contaminated from use of impure water, contamination form ice-making machines, or from improper storage or handling of ice. Review showed the policy directed staff to clean the ice storage compartment at least monthly and to scrub all surfaces using a clean cloth and fresh detergent/disinfectant solution. Review showed the policy did not contain direction to staff related to maintenance of the ice machine drain and surrounding areas. Review of the facility's Cleaning Schedules policy, dated April 2011, showed daily, weekly, and monthly cleaning schedules prepared by the Dining Services Manager with all cleaning tasks listed will be posted in the dietary department. Review showed the policy directed staff to post the cleaning schedule prior to the beginning of each week and the employee will initial in the column under the day the task is completed. Review of the facility's weekly cleaning schedule, undated, showed the cleaning schedule directed staff to clean the ice machine weekly. Review of the facility's weekly cleaning schedule records posted in the kitchen, dated February 2024 and March 2024, showed staff did not document they cleaned the ice machine. Review of the cleaning schedules posted, showed the records did not contain a weekly cleaning schedule for April 2024. Review of the facility's monthly cleaning schedule, undated, showed the cleaning schedule directed staff to sanitize the ice machine monthly. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's monthly cleaning schedule records posted in the kitchen, dated February 2024 and March 2024, showed staff did not document they sanitized the ice machine. Review of the cleaning schedules posted, showed the records did not contain a monthly cleaning schedule for April 2024. Observations on 04/15/24 at 10:40 A.M., showed an accumulation of lime and calcium scale on the exterior of the ice machine in the dining room. Observation also showed an excessive accumulation of dirt and debris behind and beneath the machine and the drain to the ice machine did not contain a visible air gap. Observation on 04/16/24 at 10:00 A.M. showed an accumulation of lime and calcium scale on the exterior of the ice machine and an excessive accumulation of dirt and debris behind and under machine. Observation showed drain to ice machine led into an enclosed space at the bottom of the adjacent cabinet and the end of drain could not been seen. During an interview on 04/16/24 at 12:45 P.M., the maintenance director said he/she did not know where the ice machine drained too and he/she does not clean the ice machine. Observation on 04/16/24 at 3:00 P.M., showed maintenance director broke open the base of the cabinet adjacent to the ice machine. Observation showed the ice machine drain ended beneath the cabinet and drained into a vent covered drain in the floor. Observation showed an excessive accumulation dirt, debris, an unidentifiable black substance and an unidentifiable white fuzzy substance on the ice machine drain, vent cover and surrounding areas. During an interview on 04/17/24 at 10:45 A.M., the DM said he/she thought the ice machine drained under the machine and did not know that the machine drained underneath an enclosed space beneath the cabinet. The DM said the dietary staff are supposed to clean the inside of the ice machine, but he/she did not know they also needed to clean the outside of the machine and surrounding areas, so no one had done so. The DM said he/she just found out that day that it was his/her responsibility to maintain the whole ice machine. During an interview 04/17/24 at 11:38 A.M., the administrator said the dietary department is responsible to clean the ice machine as needed and at least monthly. The administrator said dietary staff should clean the inside and outside of the machine as well as the surrounding walls and floors. The administrator said he/she did not know that the ice machine drained into an enclosed space beneath the cabinet. 5. Review of the facility's Cleaning Schedules policy, dated April 2011, showed daily, weekly, and monthly cleaning schedules prepared by the Dining Services Manager with all cleaning tasks listed will be posted in the dietary department. Review showed the policy directed staff to post the cleaning schedule prior to the beginning of each week and the employee will initial in the column under the day the task is completed. Review of the facility's daily cleaning schedule, undated, showed the cleaning schedule directed staff to sweep and mop the floors daily. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's daily cleaning schedule records posted in the kitchen, dated February 2024 and March 2024, showed staff only documented that they swept and mopped the floors on 02/05/24, 02/06/24, 02/10/24 and on two undated days in March 2024. Review of the cleaning schedules posted, showed the records did not contain a daily cleaning schedule for April 2024. Review of the facility's weekly cleaning schedule, undated, showed the cleaning schedule directed staff to clean the stove, walls and storage room weekly. Review of the facility's weekly cleaning schedule records posted in the kitchen, dated February 2024 and March 2024, showed staff did not document that they cleaned the stove, walls and storage room. Review of the cleaning schedules posted, showed the records did not contain a daily cleaning schedule for April 2024. Review of the facility's monthly cleaning schedule, undated, showed the cleaning schedule directed staff to clean the oven, fryer and baseboards monthly. Review of the facility's monthly cleaning schedule records posted in the kitchen, dated February 2024 and March 2024, showed staff only documented that they cleaned the oven during the second week of March 2024 and the fryer during the first week of February 2024. Review showed staff did not document that they cleaned the baseboards. Review of the cleaning schedules posted, showed the records did not contain a monthly cleaning schedule for April 2024. Observations on 04/15/24 at 10:03 A.M. during the initial kitchen tour, showed: -an accumulation of dried liquid and food debris on the wall in the food service area; -an accumulation of grease deposits and food debris on the exterior top and interior of the convection oven; -the baseboard by the kitchen door pulled away from the wall which exposed the underlying adhesive and an accumulation of debris. Observation on 04/16/24 at 10:27 A.M., showed an accumulation of dust and debris on the rungs of the can storage rack. Observations showed multiple food cans stored on the rack. Observation on 04/17/24 at 9:18 A.M., showed: -an accumulation of grease deposits and food debris inside the convection oven and on the side of range by the fryer; -an excessive accumulation of trash and food debris on floor behind range, fryer and convection oven; -an accumulation of trash and food debris under the steamtable and the microwave counter; -brown splatter stains on the wall between the steamtable and coffee maker. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 04/17/24 at 10:48 A.M., the DM said he/she had a lot of new staff and he/she instituted the cleaning lists in February 2024. The DM said the staff were trained to do the tasks listed and to sign off on the schedules when done, but he/she had issues with staff doing the cleaning or they clean and do not document that they completed the task. The DM said staff should sweep and mop the floors daily, which included under the counters and equipment and he/she knew there had been a problem with staff not doing that well enough. The DM said the can storage rack and walls should also be cleaned as needed. During an interview on 04/17/24 at 11:45 A.M., the administrator said all kitchen staff are responsible for the cleanliness of the kitchen with oversight from the DM. The administrator said the floors should be swept and mopped daily and staff should sweep and mop under and behind equipment when they clean the floors daily. The administrator said staff should clean the walls and equipment as needed and he/she would expect them to clean spills right away. The administrator said if something needs repaired, staff should document it on the maintenance log so it can be repaired. The administrator said he/she did not know about the issues in the kitchen. 6. Review of the facility's Handwashing policy, dated April 2011, showed the policy did not contain direction to staff on when to perform hand hygiene. Observation on 04/16/24 at 11:57 A.M., showed DA B lifted the trash can lid with his/her bare hands to dispose of trash and then, without performing hand hygiene, donned a pair of gloves and made grilled cheese sandwiches for service to residents at the lunch meal. Observation showed the DA used his/her gloved hand to lift the trash can lid and dispose of trash a second time, removed the soiled glove, and then, without performing hand hygiene, donned a new glove and continued to prepare grilled cheese for service. Observation on 04/17/24 at 9:34 A.M., showed DA C used lifted the trash can lid with his/her bare hand to dispose of trash and then, without performing hand hygiene, put cleansed dishes away from the clean side of the mechanical dishwashing station. During an interview on 04/17/24 at 9:37 A.M., DA C said he/she had worked at the facility for a month and staff trained him/her on hand hygiene procedures upon hire. The DA said staff should wash their hands after they touch anything dirty. The DA said a trash can lid would be considered dirty and he/she just forgot to wash his/her hands before he/she put the clean dishes away. Observation on 04/17/24 at 9:53 A.M., showed the DM lifted the trash can lid with his/her bare hand to dispose of trash and then, without performing hand hygiene, obtained a dish storage tray bar mat and placed the mat on the dish storage shelf by the steamtable. During an interview on 04/17/24 at 9:53 A.M., the DM said staff should wash their hands after they touch anything dirty and when they change gloves. The DM said a trash can lid would be considered dirty and he/she did not think to wash his/her hands after he/she touched the lid. The DM said all staff are trained on hand hygiene upon hire. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 04/17/24 at 11:41 A.M., the administrator said staff should wash their hands as needed when soiled, which would include after they touch the trash can and after they remove gloves. The administrator said staff are trained on hand hygiene procedures upon and during random in-services and the DM is responsible to monitor dietary staff hand hygiene practices routinely when on duty. 37131		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 48982 Based on observation, interview, and record review, facility staff failed to 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 infections when staff failed to perform hand hygiene in a manner to reduce the spread of infection for four residents (Resident #15, #18, #23, and #347) of four sampled residents, and failed to disinfect a multi-use glucometer (a medical device for determining the approximate concentration of glucose in the blood) between two residents (Resident #15, and #23) of two sampled residents. The facility census was 84. 1. Review of the facility's policy titled, Blood Glucose Monitoring, dated March 2015, showed staff were directed to: -Place the equipment on a clean surface such as a clean towel; -Put on gloves; -Obtain blood sugar; -Disinfect glucose monitor; -Remove gloves and wash hands. Review of the facility's policy titled Handwashing, dated March 2015, showed staff were directed to use a disposable hand towel to dry hands well and turn off faucet. Review of the facility's policy titled Gloves, dated March 2015, showed staff wear gloves when it can be reasonably anticipated that hands will be in contact with non-intact skin, any moist body substance (blood, urine, feces, wound drainage, oral secretions, sputum, vomit, or items/surface soiled with these substances). Handling medical equipment and devices with contaminated gloves is not acceptable. 2. Observation on 04/15/24 at 2:48 P.M., showed Licensed Practical Nurse (LPN) V entered Resident #23's room to performed a finger stick (to check a blood sugar) and administered insulin (medication used for diabetes). Observation showed the LPN sanitized his/her hands, applied gloves, opened the medication cart, removed a glucometer and insulin. Observation showed the LPN did not clean the glucometer, placed it on the resident's bedside table without a barrier, and performed a finger stick with the glucometer. The LPN removed his/her gloves, washed his/her hands, turned the water off with his/her bare hands, dried his/her hands with a paper towel, wiped the glucometer with an alcohol pad, and placed it top of the medication cart on the paper towel he/she dried his/her hands with. The LPN returned to the resident's room, administered the resident's insulin, and wiped blood from the resident's abdomen with an alcohol pad without gloves on. (continued on next page)		

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 04/18/2024
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.			
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Observation on 04/15/24 at 3:00 P.M., showed LPN V entered Resident #15's room to performed a finger stick and administered insulin. LPN V sanitized his/her hands, applied gloves, opened the medication cart to obtain supplies, removed a glucose strip from the canister and placed it in the glucometer that sat on the same paper towel he/she previously dried his/her hands with. The LPN placed the glucometer on the resident's bedside table, without a barrier, performed the finger stick, removed his/her gloves and returned to the medication cart without washing his/her hands. LPN V removed the resident's insulin pen from the insulin box, took the insulin pen to the resident's room, and placed the insulin pen on the resident's bedside table, without a barrier. LPN V applied gloves, administered the resident's insulin, returned to the medication cart with the same gloves on, and placed the insulin pen in the insulin box with other residents' insulin pens. During an interview on 04/15/24 at 2:48 P.M., LPN V said the facility is currently out of Sani-wipes and he/she has been cleaning the glucometer with alcohol pads. The LPN said he/she forgot to clean the glucometer before he/she checked resident #23's blood glucose. The LPN said he/she realized he/she did not wear gloves when he/she administered the resident's insulin and said he/she should have due to the risk of exposure. The LPN said gloves are not always in the resident rooms and he/she can't always find some to put on. During an interview on 04/18/24 at 10:10 A.M., LPN V said staff should wash their hands before and after resident care, when soiled, and with glove changes. The LPN said the proper way to wash hands is to use hot water, lather with soap and scrub for 30 seconds making sure to get in between fingers. Rinse by gravity from the wrist down. A paper towel should be used to dry hands, and different paper towel should be used to turn the water off. to dry hands. LPN V said staff should not turn the water of with their bare hands as this causes recontamination. The LPN said he/she did not realize he/she had turned the water off with his/her bare hands. The LPN said glucometers should be disinfected between each use with a Sani-wipe. The LPN said he/she should not have set the clean glucometer on the paper towels he/she used to dry his/her hands with as it caused re-contamination. The LPN said there should be a clean barrier between supplies and a resident's bedside table. The LPN said he/she did not remember laying supplies directly on the resident's bedside table. During an interview on 04/17/24 at 2:22 P.M., the Assistant Director of Nursing (ADON) said he/she is aware the facility only had one container of Sani-wipes. The ADON said Certified Nurse Assistant (CNA) O orders supplies. During an interview on 04/17/24 at 2:51 P.M., Certified Nurse Aide (CNA) O said he/she is responsible for ordering supplies and has been for two months. CNA O said he/she places an order every two weeks and orders Sani-wipes each time. CNA O said the Sani-wipes will be delivered by 04/18/24. 4. Observation on 04/16/24 at 8:24 A.M., showed the ADON administered insulin to Resident #347. The ADON sanitized his/her hands, removed supplies from the medication cart, applied gloves, entered the resident's room and administered insulin. The ADON returned to the medication cart, with the same gloves on, picked the insulin pen cap up from the top of the cart and put it on the pen, he/she removed his/her gloves and did not wash his/her hands. The ADON signed the medication out in the Electronic Medication Administration Record (e-MAR), and did not sanitized his/her hands. (continued on next page)		

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 04/18/2024
NAME OF PROVIDER OR SUPPLIER Warrenton Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 04/16/24 at 8:27 A.M., showed the ADON administered insulin and Norco (a pain medication) to Resident #18. The ADON sanitized his/her hands and removed the medications from the medication cart. The ADON administered the resident's insulin without gloves on, and left the room without performing hand hygiene. The ADON put the insulin pen back in the insulin box with the other resident's insulin pens. During an interview on 04/16/24 at 8:27 A.M., the ADON said he/she realized he/she did not wear gloves while giving the resident their insulin and said he/she should have. The ADON said without gloves on he/she and the resident are at risk for exposure. The ADON said he/she should have washed his/her hands before returning the insulin pens to the insulin box. 5. During an interview on 04/17/22 at 2:22 P.M., the ADON said staff should wash hands before and after resident care, with glove changes, and when soiled. The ADON said the proper way to wash your hands is to use hot water, lather with soap for 20 seconds, rinse by gravity allowing the water to drain wrist to fingers, and dry hands with a paper towel. A new paper towel should be used to turn the water off. The ADON said staff should not turn the water off with bare hands because the hands are recontaminated and can spread germs. The ADON said a glucometer should be cleaned with a Sani-wipe before and after use. The ADON said a barrier should be used between a glucometer and insulin pen when placing them on a bedside table. The ADON said staff should not set a clean glucometer on paper towels used to dry their hands. During an interview on 04/18/24 at 11:20 A.M., the Director of Nursing (DON) said staff should wash their hands before and after giving care, with any glove changes, and if they become soiled. The DON said staff should turn the water off with a clean paper towel. He/She said they should not turn the water off with their bare hands as this causes contamination and can spread infection. The DON said staff are expected to clean the glucometer with a Sani-wipe for three minutes between each use. He/She said staff should not set a clean glucometer on paper towels previously used to dry their hands as the machine becomes contaminated again. The DON said a barrier should be used between a resident's bedside table and glucometer or insulin pens to prevent contamination. During an interview on 04/18/24 at 1:13 P.M., the administrator said he/she expects staff to wash their before and after care, with glove changes, when moving from dirty to clean tasks, and when soiled. The Administrator said staff should use hot water, lather hand with soap and dry with paper towels. Staff should use a clean paper towel to turn the water off. He/She said staff should not turn the water off with bare hands as this causes contamination and can spread infection. The administrator said staff should clean the glucometer with a Sani-wipe for at least three minutes, wrap the glucometer in the wipe, and allow it to dry between resident use. Staff should not set a clean glucometer on paper towels used to dry their hands as the machine becomes recontaminated. The administrator said an alcohol pad is not a substitute for cleaning the glucometer with a Sani-wipe. The administrator said staff should use a clean barrier before placing glucometers and insulin pens on a residents' bedside table.		