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 01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warrenton Manor	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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, facility staff failed to report two separate allegations of resident-to-resident physical abuse involving one resident (Resident #1) to the Department of Health and Senior Services (DHSS) within the two-hour required timeframe. The facility's census was 89.1. Review of the facility's Abuse Prevention Policy, dated 11/28/2016, showed physical abuse includes, but is not limited to, hitting, slapping, punching, biting, and kicking. All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but no later than two hours after the allegation is made, if the events that cause the allegation involve abuse (ALL abuse allegations are to be reported within two hours), or if an event, results in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. 2. Review of Resident #1's Annual Minimum Data Set (MDS), a federally mandated assessment tool, dated 11/22/25, showed staff assessed the resident with moderate cognitive impairment, diagnoses to include Dementia, Alzheimer's disease, difficulty speaking and understanding others, and independent with ambulation. Review of the resident's progress notes, dated 12/18/25, showed Licensed Practical Nurse (LPN) B documented staff reported Resident #1 was banging on the exit doors of the secured unit, staff redirected Resident #1 away from the door, Resident #1 began to pace the hallway where another resident (Resident #2) was walking towards him/her. Resident #1 grabbed Resident #2 and hit him/her multiple times, which caused Resident #2 to hit Resident #1 in return, staff immediately separated both residents, notified LPN B of the altercation, residents assessed with no injuries, denied pain or discomfort, Resident #1 placed on 15-minute checks, management on call made aware of incident, physician and responsible party notified, Resident #1 sent to the emergency room for evaluation.During an interview on 01/15/26 at 11:24 A.M., the administrator said he/she was not aware of the documented incident on 12/18/25, the incident should have been reported to DHSS within two hours, and he/she does not know why the nurse did not submit an initial report to DHSS.During an interview on 01/15/26 at 12:45 P.M., LPN A said all allegations of abuse or witnessed physical altercations between residents should be reported to DHSS within two hours. LPN A said LPN B notified him/her via phone of the incident, he/she instructed LPN B to start the investigation, fill out an after hours self-report form and submit to DHSS. LPN A said when he/she arrived at facility, LPN B had already left, the self-report form was incomplete, and since it was past the two-hour timeframe, he/she took the completed form to the administrator for guidance, and did not know the administrator did not submit the report to DHSS.During an interview on 01/15/26 at 4:33 P.M., LPN B said all allegations of abuse or witnessed physical altercations between residents should be (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

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 01/15/2026

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reported to DHSS within two hours, but he/she did not submit a report to DHSS. LPN B said he/she was told since it was the end of his/her shift, a member of management would take care of it, and LPN A who was the manager on duty, said he/she was on the way to the facility and would complete the report and submit to DHSS. 3. Review of Resident #2's Quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively intact, diagnoses to include cognitive deficits following Nontraumatic Intracerebral Hemorrhage (a type of stroke), and independent with ambulation.Review of the facility's investigation, dated 01/07/26, showed staff documented Resident #2 came out of his/her room holding Resident #1's arms and asked staff for help but before staff could intervene, Resident #1 hit Resident #2 on the left side of his/her face and Resident #2 hit Resident #1 by his/her mouth, staff separated/redirected the residents, notified the nurse who assessed both residents, placed the residents on 15 minute checks, notified the DON, ADON, the physician and responsible parties. The report did not contain documentation facility staff reported the allegation to DHSS within the two-hour timeframe. Review of the DHSS complaint/facility self-report database did not contain documentation the facility reported the allegation of physical abuse between the residents. During an interview on 01/15/26 at 1:20 P.M., the administrator said he/she investigated the incident on 01/07/26 but thought it was Resident #1's first physical altercation with another resident, and since there were no injuries to either resident, no suspicion of abuse, and staff immediately placed interventions in place, he/she did not report the incident to DHSS. The administrator said now that he/she is aware of the incident on 12/18/25, he/she should have reported the incident on 01/07/26 to DHSS within two hours.Intake# 2713416