STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265249	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maries Manor	174 Ballpark Road Vienna, MO 65582

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review, facility staff failed to ensure one resident (Resident #1) remained free from accidents when Resident #1 received Resident #2's medications. The facility census was 66. 1. Review of the facility's Medications, Errors and Drug Reactions policy, undated, showed staff are directed to safeguard the resident and provide emergency care as needed. Complete a resident assessment every shift for at least seventy-two hours. The policy did not address contacting the pharmacy after a medication error.Review of the facility's Medication Administration Guidelines policy, undated, showed it is the purpose of this facility that residents receive their medications on a timely basis and accordance with established policies. Drug administration shall be defined as an act in which an authorized person, in accordance with all laws and regulations governing such acts, gives a single dose of a prescribed drug or biological to a resident. The complete act of administration entails removing an individual's dose from a previously dispensed, properly labeled container (including a unit dose container), verifying it with the physician's orders, giving the individual dose to the proper resident, and promptly recording the information. Medications may not be prepared in advance and must be administered within one hour of preparation.2. Review of Resident #1's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 11/10/25, showed staff assessed the resident as cognitively intact.Review of the resident's plan of care plan, dated 11/15/25, showed staff were directed to administer medications as ordered.Review of the resident's Physician Order Sheet (POS), undated, showed the POS did not contain an order for Lithium (used to stabilize mood) 1500 milligram (mg) tablet, Sertraline (used to treat antidepression) 75 mg tablet, Synthroid (used to treat an underactive thyroid gland) 200 microgram (mcg) tablet, or Topiramate (used to treat seizures and prevent migraines) 150 mg tablet.Review of the resident's progress note, dated 11/29/25, showed Licensed Practical Nurse (LPN) C documented Resident #1 received Resident #2's medications of Lithium 1500 mg, Sertraline 75 mg, Synthroid 200 mcg and Topiramate 150 mg. Review showed the nurse prepared medication to administrated and resident had noted he/she wanted to take his/her medications closer to 10:00 P.M., LPN C documented Resident #1 approached him/her at approximately 9:45 P.M., requesting medication be placed in pudding. He/She documented he/she grabbed a pudding container out of cart and opened it. He/She documented at the time the nurse he/she placed the pudding onto medication cart, Resident #1 picked up medication cup that was placed on top of med cart and dumped them into the pudding and consumed them. During an interview on 12/10/25 at 3:10 P.M., LPN C said there were a lot of behaviors by residents during the day of the medication error. He/She had got Resident #1's medications together, took it to him/her, but the resident refused and wanted it later. He/She said he/she went back to the cart and locked the medications in the top cart. He/She said he/she had taken Resident #2's medication to him/her and he/she refused, so he/she placed the medications in the medication cart. He/She said he/she was helping other resident's, when Resident #1 approached him/her about his/her medication. He/She said he/she pulled the medications out (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the cart, without looking at the marked cup, and sat the medications on the cart. LPN C said Resident #1 wanted pudding to put the medications in, so he/she reached to grab a spoon. He/She said while he/she grabbed a spoon, Resident #1 picked up Resident #2's medications off the cart and ingested before he/she had a chance to verify he/she had pulled the correct medications from the cart. He/She said he/she never handed the medications to Resident #1. During an interview on 12/09/25 at 12:22 P.M., the administrator said staff are directed to identify the resident prior to administering medications. He/She said staff are directed to administer medication to one resident at a time. He/She said LPN C was assisting several other residents at the same time, which caused him/her to be overwhelmed, at the time of the medication error. During an interview on 12/09/25 at 12:23 P.M., the DON said staff are educated to verify the identity of the resident prior to administering medications. He/She said staff are directed to administer medication to one resident at a time. He/She said LPN C was overwhelmed when assisting several other residents at the same time of the medication error. Complaint #2682543