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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Camdenton Windsor Estates		STREET ADDRESS, CITY, STATE, ZIP CODE 2042 N Business Route 5 Camdenton, MO 65020	

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** 42815 Based on interview and record review, facility staff failed to report an allegation of physical abuse for one resident (Resident #1) out of one sampled residents to the Department of Health and Senior Services (DHSS) within the two hour required timeframe. The facility census was 50. 1. Review of the facility's Investigation policy, undated, showed all allegations of abuse will be reported no later than two hours to the State Survey Agency and if applicable, law enforcement, and there are instances where an alleged violation of abuse, neglect, misappropriation of resident property and exploitation would be considered to be a reasonable suspicion of a crime. In these cases, the facility is obligated to report to the Administrator, to the state survey agency, and to other officials in accordance with State Law. 2. Review of Resident #1's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 10/24/24, showed staff assessed the resident as admitted on [DATE] with severe cognitive impairment. Review of the facility's investigation, dated 11/15/24, showed the facility documented Certified Nurse Aide (CNA) A reported to the administrator on 11/15/24 at 4:10 P.M., Registered Nurse (RN) B hit Resident #1 and threw a sheet over his/her head at 2:30 A.M. on 11/15/24. Reviewed showed staff documented they notified DHSS on 11/15/24 at 5:04 P.M During an interview on 11/09/24 at 9:30 A.M., the administrator said CNA A reported RN B slapped the resident and threw a fitted sheet over his/her head. He/She said it occurred around 3:30 A.M. on 11/15/24, but CNA A did not report the incident until later in the afternoon. He/She said CNA A did not know to report allegations of abuse immediately. He/She said he/she educated the CNA of his/her responsibility to notify him/her as soon as abuse was witnessed. During an interview on 11/09/24 at 2:25 P.M., RN B said staff are directed to immediately notify upper management and the State agency within two hours of reported or observed abuse. During an interview on 11/09/24 at 2:43 P.M., CNA A said he/she did not know he/she was supposed to report abuse within two hours to the administrator. CNA A said he/she was directed to make a report as soon as he/she was able to. CNA A said he/she did report to the administrator when he/she first had contact with him/her. CNA A said he/she was educated after the incident to report abuse immediately. (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
	265091	A. Building B. Wing	11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Camdenton Windsor Estates	2042 N Business Route 5 Camdenton, MO 65020

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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	MO00245237