STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265520	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Webco Manor	1687 West Washington Marshfield, MO 65706

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. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse were reported immediately to facility management and within two hours to the State Survey Agency (Department of Health and Senior Service (DHSS) when the facility failed to report one resident's (Resident #1) allegation of abuse by a staff member in a timely fashion. The facility census was 56.Review of the facility's policy titled. Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised April 2021 showed the following:-All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported;-If resident abuse, neglect, exploitation, misappropriation of resident property, or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law;-The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: the state licensing/certification agency responsible for surveying/licensing the facility; the local/state ombudsman; the resident's representative; adult protective services (where state law provides jurisdiction in long-term care); law enforcement officials; the resident's attending physician; and the facility medical director;-Immediately is defined as within two hours of an allegation involving abuse or resulting in serious bodily injury; or within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.1. Review of Resident #1's face sheet (a document that gives a resident's information at a quick glance) showed the following information:-admission date of 02/16/21.-Diagnoses included altered mental status, peripheral vascular disease (a condition that affects the blood vessels), heart failure, depression, high blood pressure, dementia, and Alzheimer's (irreversible brain disorder that causes memory loss, cognitive decline and changes in behavior and personality). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff), dated 08/08/25, showed the following:-Resident had severe cognitive impairment.-Resident required total assistance from staff for activities of daily living.Review of the facility's investigation, dated 10/07/25, showed the following:-On 10/01/25, approximately 6:30 P.M., the resident was yelling out and Certified Nurse Aide (CNA) A attempted to calm and redirect the patient. CNA B saw this and was concerned with the calming/redirection style the CNA A used; -CNA B was interviewed and reported she/he witnessed CNA A cover the mouth of the resident while saying for her to be quiet. This took place in the resident's room while two of them were putting the resident to bed.-On 10/02/25, CNA B told CNA C that CNA A had put his/her hand over the resident's mouth and told the resident to shut the fuck up. CNA C told CNA B that he/she needed to report this to the Director of Nursing (DON) and/or the Administrator. CNA B said no, so CNA C reported the alleged abuse to the DON and the Administrator.(Staff did not document reporting the allegation of abuse to DHSS.) Review of the resident's nurses' note showed did not document reporting the allegation of abuse to DHSS.Review of DHSS records showed the facility reported the allegation of possible abuse involving the resident and CNA A on 10/02/25 at 7:39 P.M. (the day after the alleged abuse was observed by facility staff). During an interview on 10/09/2, at 1:58 P. M., CNA A said the following:-If he/she saw abuse he/she would intervene and report the abuse to the charge nurse;-Allegations of abuse are reported to the state within two hours.During an interview on 10/09/25, at 3:07 P.M., CNA B said the following:-If he/she saw abuse he/she would report the abuse to the charge nurse and the DON if needed;-On 10/01/25, he/she [NAME] he/she did observe abuse. He/she saw an CNA A place his/her hand over the resident's mouth and yelled at the resident to shut up. The resident was crying;-He/she did not report it that day, but the next day, on 10/02/25, he/she told CNA C and CNA C reported the abuse to the DON;-He/she should have reported the abuse immediately; -All abuse has to be reported to the state within 2 hours.During an interview on 10/09/25, at 11:55 A.M., CNA C said the following:-All abuse should be reported immediately to the charge nurse, DON, and/or the Administrator;-All abuse should be reported to the state within two hours.During an interview on 10/09/25, at 12:15 A.M., CMT D said the following:-If he/she witnessed any abuse he/she would report to the charge nurse and would go to the DON and administrator if necessary;-All abuse should be reported immediately and has to be reported to the state within two hours.During an interview on 10/09/25, at 2:33 P.M., Registered Nurse (RN) E said the following:-He/she would report all allegations of abuse to the DON and the Administrator;-All allegations of