

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/21/2026
NAME OF PROVIDER OR SUPPLIER Webco Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on interview and record review, the facility failed to ensure all allegations of possible abuse were reported timely to State Survey Agency (SSA - Department of Health and Senior Services (DHSS)) when staff failed to report an allegation of staff to resident abuse within the required two hours of the facility staff becoming aware of the allegation involving one resident (Resident #1). The facility census was 64. Review of the facility's Abuse and Neglect Policy, undated, showed the following information:-Types of abuse include physical, verbal, sexual, mental, and financial exploitation;-All employees are mandated reporters;-Any suspicion or knowledge of abuse, neglect, or misappropriation must be reported immediately to the Administrator and charge nurse;-The Administrator or Director of Nursing (DON) or designee must begin an internal investigation immediately and report to DHSS;-Reports must be made to the Missouri DHSS within two hours if allegation alleges serious injury or 24 hours if it does not allege serious injury. 1. Review of Resident #1's face sheet (a brief resident profile sheet) showed the following information:-admission date of 02/02/24;-Diagnoses included multiple sclerosis (an autoimmune disease disrupting brain to body communication).Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 12/15/25, showed minimal cognitive impairment.Review of the resident's care plan, last reviewed on 12/01/25, showed the following information:-Communication problems related to diagnoses;-Provide resident with supportive care and services.Review a written statement by Certified Nurse Aide (CNA) A's statement dated 01/18/26, between 2:00 A.M. and 2:25 A.M., showed the following: -He/she went into the resident's room to change the resident's brief when the resident reported to her that CNA B came into his/her room, turned on the bright light;-The resident yelled hey at CNA B;-The resident said he was upset that CNA B turned on the bright light because he/she was sleeping;-The resident said that CNA B has a bad temper and was being very rough while attempting to change the resident;-The resident told CNA B to stop. CNA B then punched the wall three times above his head and walked out of the room;-The resident told CNA A that he/she was fearful of CNA B and did not want him/her back in his/her room;-CNA A immediately reported the incident to Registered Nurse (RN) C;-CNA A then asked CNA B what had happened in the resident's room. CNA B told CNA A that the resident yelled at him/her for being rough during cares and he/she left the resident's room;-CNA A wrote out a statement regarding the incident;-On 01/18/26, at 2:54 A.M., CNA A sent a picture of his/her written statement to the DON via text message. CNA A did not receive a response;-On 01/18/26, at 2:56 A.M., CNA A attempted to call the DON, and then the Administrator. Neither answered their phone;-On 01/18/26, at 3:04 A.M., CNA A sent a picture of his/her written statement to the Administrator.During an interview on 01/21/26, at 2:15 P.M., CNA A said the following: -On 01/18/26, at approximately 2:00 A.M., he/she entered the resident's room;-The resident told him/her that CNA B came in his/her room, turned on the bright light, and was rough with cares. The resident told CNA B to stop. CNA B became upset and hit the wall three times above the resident's head before leaving</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 265520	Facility ID: 265520 If continuation sheet Page 1 of 5

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>his/her room; -He/she immediately reported the incident to RN C;-He/she wrote out his/her statement; -He/she tried to call the DON and the Administrator, however neither party answered their phone; -CNA A took a picture of his/her written statement and sent it to both the DON and the Administrator via text message;-If a resident stated that staff was rough with cares that was an allegation of abuse and should be reported immediately to the charge nurse, DON, or the Administrator. The facility had two hours to report abuse allegations to the State. Review of a written statement by RN C's, dated 01/18/26, no time noted, showed the following information:-On 01/18/26, between 2:00 A.M. and 3:00 A.M., CNA A reported to him/her that the resident was upset with CNA B because CNA B was rough during cares;-The resident told CNA B to stop. CNA B backed off, apologized to the resident and left the room;-CNA B became upset and punched the wall in the hallway outside of the resident's room;-RN C told CNA B to not enter the resident's room for the remainder of the shift and assigned CNA A to the resident's room for the remainder of the shift;-RN C reported the incident to the day shift nurse during shift report.(The RN did not document reporting the allegation of possible abuse to management or DHSS.)During an interview on 01/21/26, at 1:15 P.M., RN C said the following:-On 01/18/26, between 2:00 A.M. and 3:00 A.M., CNA A reported to him/her that the resident complained that CNA B was rough when providing cares and then CNA B punched the wall in the hall outside of the resident's room;-Rough with cares was not an allegation of abuse and did not report the allegation to the DON or the Administrator.Review of the written statement by the DON, no date or time noted, showed the following information:-The DON interviewed CNA B regarding the allegation;-CNA B said that he/she entered the resident's room and turned on the light;-The resident did not like the light on;-The resident became upset with how CNA B was rolling the resident and told CNA B to stop;-CNA B stepped back and left the room;-CNA B denied punching anything in the building.Review of the Administrator's written statement dated 01/18/25, no time noted, showed the following:-On 01/18/26, the Administrator called RN C to discuss the occurrence between the resident and CNA B;-The Administrator asked RN C to write a statement for the investigation;-On 01/18/26, the Administrator spoke with CNA A regarding the investigation;-The Administrator educated CNA A that texting him/her an abuse or neglect allegation was not an appropriate way to notify him/her of an allegation, and he/she expected to be called for any future abuse or neglect allegations;-On 01/21/26, the Administrator spoke with CNA B regarding the incident;-The Administrator educated CNA B that all abuse or neglect allegations must be reported, even when the allegation was against oneself;-On 01/18/26, at 9:54 A.M., family was notified of the allegation of abuse;-On 01/18/26, at 9:59 A.M., the physician was notified of the allegation of abuse.Review of the resident's progress notes showed staff did not document information pertaining to the allegation of abuse.Review of DHSS records showed an online report was made regarding the allegation of abuse on 01/18/26, at 9:58 A.M. (over seven hours after staff became aware of the allegation of possible abuse.)During an interview on 01/21/26, at 11:40 A.M., RN D said the following: -Abuse can be verbal, sexual, physical, emotional, or financial;-Any allegation of abuse should be reported to the DON or Administrator immediately. -The facility has two hours to report an abuse allegation to state;-If a resident reported rough cares and he/she didn't feel safe, that should be considered an abuse allegation and reported immediately.During an interview on 01/21/26, at 11:45 A.M. CNA E said the following: -Abuse should be reported to the charge nurse immediately;-The facility had two hours to report to State;-He/she would consider rough cares abuse.During an interview on 01/21/26, at 11:50 A.M., Certified Medication Technician (CMT) F said the following: -Abuse could be verbal, physical, sexual, mental, and financial;-He/she would notify his/her charge nurse immediately of any allegation of abuse. -The facility had two hours to report abuse to State.During an interview on</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>01/21/26, at 11:54 A.M., CNA G said the following: -Abuse could be financial, verbal, physical, emotional and sexual;-He/she would notify the charge nurse or the Administrator of any allegation of abuse;-The facility has two hours to report abuse to the State;-If a resident reported rough cares he/she would consider that an abuse allegation and would report it immediately.During an interview on 01/21/26, at 11:59 A.M., CMT H said the following: -Abuse could be verbal, physical, mental, sexual and financial;-He/she would notify his/her charge nurse, DON, or the Administrator immediately of an allegation of abuse;-The facility had two hours to report abuse allegation to State;-An allegation of rough cares should be reported.During an interview on 01/21/26, at 3:00 P.M., the DON said the following: -On 01/18/26, at 2:54 A.M., he/she received a written statement via a text message from CNA A;-On 01/18/26, at 2:56 A.M., he/she had a missed call from CNA A;-The DON did not respond to either the text message or the telephone call because he/she was sleeping and did not hear his/her telephone;-On 01/18/26, at 9:00 A.M., the Administrator called the DON and informed him/her of the allegation;-The DON said that rough with cares and punching a wall was abuse and should be reported to the State within two hours. During an interview on 01/21/26, at 3:20 P.M., the Administrator said the following: -On 01/18/26, at 2:56 A.M., he/she received a written statement via text message from CNA A;-On 01/18/26, at 2:56 A.M., he/she had a missed call from CNA A;-The Administrator did not respond to either the text message or the telephone call because he/she was sleeping and did not hear the telephone;-On 01/18/26, at 9:30 A.M., the Administrator called CNA A and confirmed the incident;-On 01/18/26, at 9:58 A.M., the Administrator reported the allegation to DHSS;-An allegation of rough cares was considered an abuse allegation and should be reported to DHSS within two hours. #2719698</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on interview and record review, the facility failed to ensure that all allegations of possible abuse were thoroughly and timely investigated, and steps were taken to protect all residents during the investigation, when staff did not begin an immediate investigation into an allegation staff to resident (Resident #1) abuse and the staff member continued to work independently with residents. The facility census was 64. Review of the facility's Abuse and Neglect Policy, undated, showed the following information: -Types of abuse include physical, verbal, sexual, mental, and financial exploitation; -The Administrator or Director of Nursing (DON) or designee must begin an internal investigation immediately and report to DHSS. 1. Review of Resident #1's face sheet (a brief resident profile sheet) showed the following information: -admission date of 02/02/24; -Diagnoses included multiple sclerosis (an autoimmune disease disrupting brain to body communication). Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 12/15/25, showed minimal cognitive impairment. Review of the resident's care plan, last reviewed on 12/01/25, showed the following information: -Communication problems related to diagnoses; -Provide resident with supportive care and services. Review a written statement by Certified Nurse Aide (CNA) A's statement dated 01/18/26, between 2:00 A.M. and 2:25 A.M., showed the following: -He/she went into the resident's room to change the resident's brief when the resident reported to her that CNA B came into his/her room, turned on the bright light; -The resident yelled hey at CNA B; -The resident said he/she was upset that CNA B turned on the bright light because he was sleeping; -The resident said that CNA B has a bad temper and was being very rough while attempting to change the resident; -The resident told CNA B to stop. CNA B then punched the wall three times above his/her head and walked out of the room; -The resident told CNA A that he/she was fearful of CNA B and did not want him/her back in his/her room; -CNA A immediately reported the incident to Registered Nurse (RN) C; -On 01/18/26, at 2:54 A.M., CNA A sent a picture of his/her written statement to the Director of Nursing (DON) via text message. CNA A did not receive a response; -On 01/18/26, at 2:56 A.M., CNA A attempted to call the DON, and then the Administrator. Neither answered their phone; -On 01/18/26, at 3:04 A.M., CNA A sent a picture of his/her written statement to the Administrator. During an interview on 01/21/26, at 2:15 P.M., CNA A said the following: -On 01/18/26, at approximately 2:00 A.M., he/she entered the resident's room, and the resident told him/her that CNA B came in his/her room, turned on the bright light, and was rough with cares. The resident told CNA B to stop. CNA B became upset and hit the wall three times above the resident's head before leaving his/her room; -CNA A immediately reported the incident to RN C; -CNA A then wrote out his/her statement; -CNA A tried to call the DON and the Administrator. Neither party answered their phone; -CNA A took a picture of her written statement and sent it to both the DON and the Administrator via text message; -On 01/18/26, at 9:00 A.M., the Administrator called CNA A back regarding the allegation; -CNA A said that if a resident states that staff was rough with cares that is an allegation of abuse. Review of a written statement by RN C dated 01/18/26, no time noted, showed the following information: -On 01/18/26, between 2:00 A.M. to 3:00 A.M., CNA A reported to him/her that the resident was upset with CNA B because CNA B was rough during cares; -The resident told CNA B to stop. CNA B backed off, apologized to the resident, and left the room; -CNA B became upset and punched the wall in the hallway outside of the resident's room; -RN C told CNA B to not enter the resident's room for the remainder of the shift and assigned CNA A to the resident's room for the remainder of the shift; -RN C reported the incident to the day shift nurse during shift report. During an interview on 01/21/26, at 1:15 P.M., RN C said that on 01/18/26, between 2:00 A.M. to 3:00 A.M., CNA A reported to him/her that the resident complained that CNA B was rough when providing cares, then CNA B punched the</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>wall in the hall outside of the resident's room;-RN C reassigned CNA A to the resident's room and told CNA B to not go back in the resident's room;-RN C did not go into the resident's room nor did he/she interview the resident;-RN C said that rough with cares was not an allegation of abuse and did not report the allegation to the DON or the Administrator.During an interview on 01/21/26, at 12:27 P.M., CNA B said the following: -On 01/18/26, at approximately 2:00 A.M., he/she entered the resident's room, turned on the bathroom light, and proceeded to change the resident;-The resident yelled at CNA B because he/she didn't like the way he/she was being rolled;-CNA B finished peri care and left the room;-CNA B told CNA A that the resident was upset. CNA A told CNA B that he/she would check on the resident;-Approximately 20 minutes later, RN C told him/her not to go back in the resident's room;-CNA A was reassigned to that room;-On 01/18/26, at approximately 11:00 A.M., CNA B received a telephone call from the Administrator suspending him/her pending an investigation.During an interview on 01/21/26, at 11:40 A.M., RN D said the following: -Abuse could be verbal, sexual, physical, emotional, or financial;-For any allegation of abuse, staff should ensure resident safety and report to the DON or Administrator immediately;-If a resident reported rough cares and he/she didn't feel safe, that should be considered an abuse allegation. During an interview on 01/21/26, at 3:00 P.M., the DON said the following: -On 01/18/26, at 2:54 A.M., he/she received a written statement via a text message from CNA A;-On 01/18/26, at 2:56 A.M., he/she had a missed call from CNA A;-The DON did not respond to either the text message or the telephone call because he/she was sleeping and did not hear his/her telephone;-On 01/18/26, at 09:00 A.M., the Administrator called the DON informing him/her of the allegation;-The DON said that rough with cares and punching a wall was abuse. During an interview on 01/21/26, at 3:20 P.M., the Administrator said the following:-On 01/18/26, at 2:56 A.M., he/she received a written statement via text message from CNA A;-On 01/18/26, at 2:56 A.M., he/she had a missed call from CNA A;-The Administrator did not respond to either the text message or the telephone call because he/she was sleeping and did not hear the telephone;-On 01/18/26, at 9:30 A.M., the Administrator called CNA A and confirmed the incident and started an investigation;-An allegation of rough cares is considered an abuse allegation and an investigation should be started immediately. #2719698</p>		