STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265851	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silverstone Place	2735 Eagleson Dr Rolla, MO 65401

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	Based on interview, and record review, facility staff failed to report an allegation of abuse for one resident (Resident #1) out of five sampled residents, within in two hours to the administrator and the state agency (Department of Health and Senior Services). The facility census was 65.1.Review of the facility's Abuse policy, dated 01/10/2024, showed time period to report allegations of abuse and neglect establishes two-time limits for the reporting of reasonable suspicion of a crime, depending on the seriousness.-Serious Bodily Injury-two-hour limit: If the events first cause the reasonable suspicion result in serious bodily injury to a resident, the covered individual shall report the suspicion immediately, but not later than two hours after forming the suspicion.-All others-Within 24 hours: If the events that cause the reasonable suspicion do not result in serious bodily injury to a resident, the covered individual shall report the suspicion not later than 24 hours after forming suspicion.3. Review Resident #1's Face Sheet, dated 07/09/25, showed staff assessed the resident with a history of falling, cardiac pacemaker, muscle weakness, reduced mobility and Chronic Obstructive Pulmonary Disease (COPD). Review of the Facility's Investigation titled Investigation on Incident R/T Staff Vs. Resident #1, dated 07/16/25, showed the Director of Nursing (DON) documented he/she spoke with staff and residents regarding allegations of abuse on the early morning hours of 07/16/25. The investigation included the written statements of staff present during the incident as follows -On 07/16/25 Certified Medication Technician (CMT) E documented he/she witnessed CMT C and Certified Nurse Aide (CNA) B physically restrain the resident to take the resident back to his/her room. The CNA held the resident's arms down and the CMT held the resident's legs together and up, so CNA D could propel the resident in his/her wheelchair, back to his/her room. CMT E and CNA B picked the resident up and threw the resident on his/her bed. -On 07/16/25 CNA D documented he/she observed CNA B hold the resident's hands down and the resident said let me go, I'm not going to hit you. CNA B then said he/she was not going to let the resident go and told the resident, Try to get lose Motherfucker. CMT C then bent down and said to the resident, Now go ahead and punch me Motherfucker. CNA D documented he/she observed CNA B and CMT C pick the resident up under his/her arms, where his/her feet were off the ground and throw the resident into his/her bed. Review showed the investigation did not contain documentation the facility notified the Department of Health & Senior Services about this allegation of abuse within the required two hours. During an interview on 07/23/25 at 12:35 P.M., Registered Nurse (RN) A said he/she went to the resident's room to talk to him/her the morning of the incident. RN A said the resident told him/her, he/she had been cussing at the staff and the staff were cussing at him/her. RN A said if staff cussed at the resident, it would be abuse. RN A said he/she reported to the DON and administrator that the resident said staff cussed at him/her. He/She said the facility has two hours to report abuse, or allegations of abuse to the state. RN A said he/she thought the state had been notified. During an interview on 07/24/25 at 8:02 A.M., CNA D said he/she saw both CNA B and CMT C call the resident a Motherfucker and was holding the resident down against his/her will. CNA D said RN F was right outside the resident's room. CNA D said he/she exited the resident's room and told RN F what he/she observed. CNA D said RN F reported the incident to the Assistant Director of Nursing (ADON) when he/she came in. CNA D said he/she told RN F he/she felt it was abuse and RN F agreed it was abuse, he/she would have to report to management, and they would have to report it to state. What time was that? During an interview on 07/24/25 at 8:28 A.M., CMT E said he/she went into the resident's room and observed CNA B and CMT C pick the resident up where his/her feet were off the ground and threw the resident down on his/her bed, because his/her bed had already been lowered all the way to the ground. CMT E said he/she also heard the resident report to RN A the staff had cussed at him. During an interview on 07/24/25 at 8:43 A.M., RN F said CNA D reported to him/her that CNA B and CMT C called the resident Motherfucker and threw the resident into bed. RN F said he/she reported to the ADON and the ADON said he/she would report it to state. During an interview on 07/24/25 at 11:10 A.M., the ADON said he/she would say CNA D's witness statement alleges abuse. The ADON said he/she forwarded the CNA D's statement to the administrator. The ADON said he/she did not know that all allegations of abuse had to be reported to the state health agency within two hours. The ADON said CNA D later asked if it had been reported to the state, so he/she contacted the DON, and the DON said the incident had been investigated and handled appropriately. During an interview on 07/24/25 at 1:04 P.M., the DON said when he/she arrived at the facility, the administrator had taken all the statements. The DON said he/she then read the statement. The DON said he/she would consider it abuse if a staff cussed at a resident. The DON said he/she spoke