STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265666	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWSON MANOR & REHAB	210 WEST 8TH TERRACE LAWSON, MO 64062

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 563 SS=D	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one resident's visitation rights were not restricted when Resident #6 had a visitor that was asked to leave and not permitted to visit the resident. This affected one of six sampled residents (Resident #6). The	F 563		11/15/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Francis Hoke — TITLE: Administrator — (X6) DATE: 10/29/2024

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.

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F 563	Continued From page 1 facility census was 47. Review of facility policy, Resident Rights, undated, showed: -Resident has right to receive visitors of their choosing at time of their choosing and interact and participate with members of community and activities inside and outside facility, subject to resident's right to deny visitation, and in a manner that did not impose on rights of another resident. -Facility must provide immediate access, subject to resident's right to deny or withdraw consent at any time to any resident by: -Immediate family and other relatives of resident; -Facility must have written policies and procedures regarding visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction, and must inform each resident of right to receive visitors whom they designate and their right to withdraw or deny such consent any time. Review of facility policy, visiting hours, undated, showed: -Resident has right to receive visitors of his or her choosing at the time of his or her choosing, subject to resident's right to deny visitation when applicable, and in a manner that did not impose on the rights of another resident. -The facility will ensure all visitors enjoy full and equal visitation privileges consistent with resident preferences. -The facility will provide immediate access to any resident subject to the resident's rights to deny or withdraw consent at any time. -The facility will have immediate access to the resident by any of the following:	F 563		

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F 563	Continued From page 2	F 563		

-Others who are visiting with the consent of resident;
-Visiting hours will be posted to encourage reasonable restrictions.

1. Review of Resident #6's admission minimum data set (MDS), a federally mandated assessment tool completed by facility staff, dated 8/14/24, showed:
-He/She was cognitively intact;
-He/She had clear speech and was able to make self-understood and understand others;
-It was very important to have family or close friends involved in discussions about his/her care;
-He/She was independent with mobility, personal hygiene, dressing, and eating;
-Diagnoses included: anxiety (feeling of fear, dread, or uneasiness that could be normal reaction to stress), depression (mental condition that involved persistent feelings of sadness and loss of interest in activities), manic depression (serious mood disorder that can affect how person feels, thinks, or acts), diabetes (a condition resulting in too much sugar in the blood), and bipolar disorder (a mental illness that can cause extreme mood swings, along with changes in energy, activity levels, and concentration).

Review of physician's orders, dated 10/23/24, showed:
-Activities as tolerated or desired;

Review of care plan, undated, showed:
-Resident had an activity of daily living self-care performance deficit due to limited mobility;
-Encourage resident to participate to fullest extent possible with each interaction.

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F 563	Continued From page 3	F 563		

During an interview on 10/23/24 at 8:51 A.M., Resident said:
-His/Her friend, Visitor A, came to see him/her;
-The Business Office Manager (BOM) would not let his/her friend come to see him/her;
-It upset him/her that his/her friend could not come and visit them;
-He/She was his/her own person and did not have a guardian;
-The visitor who was denied access had been former employee of facility;
-He/She had a friendship with the individual and wanted to be allowed his/her right to have visits.

During an interview on 10/23/24 at 9:19 A.M., BOM said:
-He/She had never denied visits to anyone;
-If an employee was terminated from the facility they were not allowed back into the building;
-He/She was not aware of any former employees that had been at the facility to visit a resident that he/she had turned away;
-There was no visiting hours at facility, people could visit at time of choosing;
-He/She was not aware of turning any visitors that came to facility to see Resident #6.

During an interview on 10/23/24 at 10:25 A.M., Director of Nursing (DON) said:
-Facility did not have set visiting hours;
-He/She was aware of one former employee that had came to facility after hours, the former Assistant Director of Nursing (ADON), and he/she had been escorted out of facility due to making staff uncomfortable and exhibiting disturbing behaviors.

During an interview on 10/23/24 at 10:42 A.M., Licensed Practical Nurse (LPN) A said:

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F 563	Continued From page 4	F 563		

-He/She was aware of one resident, Resident #6, who had been denied a visit from visitor A by the BOM;
-The BOM told Visitor A that he/she could not come into the facility;
-Visitor A was a former employee;
-He/She observed Visitor A being denied access on two visit attempts;
-Resident #6 was his/her own person and able to make his/her own decisions.

During an interview on 10/23/24 at 11:20 A.M., ADON said:
-He/She was not aware of any residents being denied visits;
-Former employees were allowed to come back into facility to visit residents.

During an interview on 10/23/24 at 11:38 A.M., Visitor A said:
-He/She had previously worked at the facility;
-He/She voluntarily quit and left the facility on good terms;
-He/She attempted to visit Resident #6 on 9/1/24, 9/4/24, and 9/9/24;
-On his/her first attempt on 9/1/24 he/she was in facility applying for a position, after he/she completed the application he/she went down the hallway to visit the resident;
-The BOM came out of his/her office and yelled at him/her saying he/she was not allowed to go down the hallway;
-When he/she returned for an interview, he/she inquired with the Administrator if he/she could visit the resident and the Administrator said he/she was not allowed to be there;
-During a third attempt to visit the resident, the Administrator again said he/she was not allowed;
-He/She had been Certified Nurse Aide in the

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F 563	Continued From page 5 facility a long time and quit working at the facility at end of November 2023. During an interview on 10/23/24 at 12:09 P.M., DON said: -Resident #6 was his/her own responsible party; During an interview on 10/23/24 at 11:45 A.M., Administrator said: -He/She had never turned resident's visitors away from facility; -He/She had not turned away the former staff member; -Visitors were allowed to visit the facility at any time; -He/She did not turn away Visitor A; -Visitor A had been terminated and was on the facility do not rehire list; -He/She expected residents with capacity and were their own person to be allowed to have access to visitors of their own choosing. MO243891	F 563		

Missouri Department of Health and Senior Services

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	07395	A. BUILDING: _____ B. WING _____	C 10/24/2024

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A8032	19 CSR 30-88.010(31) Res Communicate With Persons of Choice Each resident shall be permitted to communicate, associate, and meet privately with persons of his or her choice whether on the resident's initiative or the other person's initiative, unless to do so would infringe upon the rights of other residents. The person(s) may visit, talk with, and make personal, social, or legal services available, inform residents of their rights and entitlements by means of distributing educational materials or discussions, assisting residents in asserting their legal rights regarding claims for public assistance, medical assistance and Social Security benefits, and engaging in any other methods of assisting, advising, and representing residents so as to extend to them the full enjoyment of their rights. The facility, however, may place reasonable limitations on solicitations. II/III This regulation is not met as evidenced by: Class III , Please refer to F563 MO243891	A8032	See F563	11/15/24

Missouri Department of Health and Senior Services
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Frances Hicks — Administrator — 10/29/24

PLAN OF CORRECTION

Provider Name:	Lawson Manor & Rehab
Street Address, City, Zip:	210 West 8th Terrace, Lawson, Mo. 64062
Date of Survey:	10/24/2024
Provider number:	265666

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	This plan of correction is prepared and executed because it is required by the provisions of the state and federal regulations and not because Lawson Manor & Rehab agrees with the allegations and citations listed on the statement of deficiencies. Lawson Manor & Rehab maintains that the alleged deficient practices do not, individually and collectively, jeopardize the health and safety of the residents nor are they of such character as to limit our capacity to render adequate care as prescribed by the regulation. This plan of correction shall operate as Lawson Manor & Rehab written credible allegation of compliance. By submitting this plan of correction, Lawson Manor & Rehab does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position and Lawson Manor & Rehab reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding	
F563	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Administrator and DON discussed concerns with Resident #6. Resident #6 was reassured that all visits with family members, friends and relatives were unlimited. Resident # 6 will experience visits per his/her choosing. How you will identify other residents having the potential to be affected by the same deficient practice. All residents were at risk of alleged deficient practice. Accommodation will be made for all residents to provide visitations and access in accordance with facility policy.	11/15/24

	What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The administrator and/or designee will in-service facility staff of residents' rights to receive visitors per facility policy without restriction and to report any violations of facility visitation policy to Administrator immediately. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. Administrator and/or SSD to review residents' rights with visitation during resident council monthly x three months, then every three months x one year How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections achieved are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. Administrator and/or SSD to report resident understanding of process of visitation to QAA committee monthly x 3 months then, QAA committee to review monthly and augment review process as necessary to maintain compliance.	
A8032	Refer to F 563	11/15/24
	.	

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.

Frances Wilkes, LNHA 10/29/2024

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	265666	A. BUILDING _____ B. WING _____	R-C 12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWSON MANOR & REHAB	210 WEST 8TH TERRACE LAWSON, MO 64062

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F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)	F 610		

§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.

§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility Administrator and Director of Nurses (DON) failed to investigate misappropriation of resident property when Resident #1 was found without a fentanyl patch (A controlled opiate, A schedule II naroctic pain patch) on two different dates. The Administrator and DON failed to conduct an investigation when Licensed Practical Nurse (LPN) B called to report the missing patch on 11/11/24 and when LPN A reported the patch missing to the DON on 11/13/24. This affected one of one sampled residents. The facility census was 46.

Review of facility policy, Abuse Investigation and Reporting, Revised July 2017, showed:
-All reports of resident abuse, neglect,

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 12/07/2024

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.

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F 610	Continued From page 1	F 610		

exploitation, misappropriation of resident property, shall be thoroughly investigated by facility management.
-Individual conducting the investigation will as a minimum:
-Review the completed documentation forms;
-Review the resident's medical record to determine events leading up to the incident;
-Interview the person(s) reporting the incident;
-Interview any witnesses to the incident;
-Interview the resident (as medically appropriate);
-Interview the resident's attending physician as needed to determine the resident's current level of cognitive function and medical condition;
-Interview staff members (on all shifts) who have had contact with the resident during the period of alleged incident;
-Interview the resident's roommate, family members, and visitors;
-Interview other residents to whom the accused employee provides care or services; and
-Review all events leading up to the alleged incident.

1. Review of Resident #1's, Quarterly minimum data set (MDS), a federally mandated assessment tool completed by facility staff, dated 8/30/24, showed:
-Cognition is severly impaired;
-He/She was dependent for upper and lower body dressing, mobility, and personal care;
-He/She had been on a scheduled pain medication regimen;
-He/She made vocal complaints of pain within the assessment reference date (The look back period for the assessment).
-He/She was taking high-risk drugs including an opioid (a broad group of pain-relieving medicines

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F 610	Continued From page 2	F 610		

that work with brain cells);
-Diagnoses included: Alzheimer's disease (a progressive brain disorder that slowly destroys memory, thinking skills, and ability to perform everyday tasks), cognitive communication deficit (a difficulty communicating effectively due to underlying cognitive impairment), reduced mobility, malaise (a general feeling of discomfort, illness, or lack of well-being)

Review of care plan, undated, showed:
-He/She had potential for pain
-Administer pain medication as ordered;
-Turn and repposition according to turn schedule;
-Observe for factors that increase/decrease my pain;
-Observe for intolerable pain;
-Measure my pain level using pain scale 1 to 10;
-Coordinate with my physician to manage my pain medication for optimum control of my pain;
-Coordinate care with hospice to maintain comfort;
-Observe for non-verbal signs of pain ie. facial expressions, pulling away, fighting;

Review of physician's orders, dated 12/4/24, showed:
-Initial order started 10/14/24, Check fentanyl patch every shift, to ensure fentanyl patch is intact;
-Fentanyl transdermal patch dosage increased on 11/15/24, to 50 MCG/HR (Fentanyl), apply 1 patch transdermal every 72 hours for pain.
-Current physician orders as of 12/4/24 show fentanyl transdermal patch 72 hour 50 mcg/hr (fentanyl), apply 1 patch transdermal every 72 hours for pain,

Review of controlled medication sheets for

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Resident #1's fentanyl patch showed:
-Page 53: Fentanyl 25 mcg, 1 patch every 72 hours, balance forwarded was 2
-On 11/6/24, at 4:00 A.M., 1 dose was given, balance was 1 patch;
-On 11/11/24 at 12:48 A.M, nothing entered as given, balance was 0;
-On 11/19/24 entry showed count corrected, balance was 1 patch;
-On 11/19/24, entry showed at 8:00 A.M. fentanyl was administered, and balance was 0.
-On Page #54: Fentanyl 50 mcg, apply 1 patch every 72 hours showed:
-On 11/7/24, at 8:00 P.M., 2 patches were received from the pharmacy;
-On 11/8/24, at 8:30 A.M., 1 patch was given, balance remaining was 1 patch
-On 11/18 an entry was made with a line through it that showed balance was 0 patches, but no administration time was entered;
-On Page #55, fentanyl 50 mcg, change every 72 hours showed:
-On 11/11/24, balance was 5 patches;
-On 11/12/24, 1 dose was given, no time of administration entered, and balance was 4 patches;
-On 11/13/24 at 6:49 A.M., 1 patch was administered, balance remaining was 3 patches;
-On 11/15/24 at 10:30 A.M., 1 patch was administered, balance remaining was 2 patches;
-On 11/18/24 at 1:00 P.M., 1 patch was administered, balance remaining was 1 patch;
-On 11/21/24 at 9:27 A.M., 1 patch was administered, balance remaining was 0 patches.
-On Page #60, fentanyl 50 mcg, apply one patch topically, showed page was started 11/18/24;
-On 11/18/24, balance received from pharmacy was 5 patches;
-On 11/24/24 at 8:00 A.M., 1 patch was

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administered, balance remaining was 4 patches;
-On 11/27/24 at 8:00 A.M., 1 patch was administered, balance remaining was 3 patches;
-On 11/30/24 at 8:00 A.M., 1 patch was administered, balance remaining was 2 patches;
-On 12/3/24 at 9:30 A.M., 1 patch was administered, balance remaining was 1 patch;
-On 12/3/24 at 9:30 A.M., 1 patch was administered, balance remaining was 0 patches, and a note written by DON showed stuck to op-site/tegaderm (sticky bandage that holds patches in place) had to replace patch.

Review of Medication Administration Record, dated 11/1/24 to 12/4/24, showed:
-Unknown start date, Fentanyl transdermal patch 72 hour 25 mcg/hr (fentanyl), apply 1 patch transdermal one time a day every 3 days for pain, discontinued on 11/7/24 at 3:50 P.M.
-Administered 11/5/24 by LPN C;
-Unknown start date, fentanyl transdermal patch 72 hour 50 mcg/hr (fentanyl), apply 1 patch transdermal every 72 hours for pain, apply 1 50 mcg/hr patch topically and change every 72 hours and remove per schedule, discontinued on 11/15/24 at 8:35 A.M;
-Administered 11/8/24 at 9:01 A.M. by LPN D;
-Administered 11/11/24 at 11:49 A.M. by Assistant Director of Nursing (ADON);
-Administered 11/14/24 at 7:37 by LPN A;
-Unknown start date, fentanyl transdermal patch 72 hour 50 mcg/hr (fentanyl), apply 1 patch transdermal every 72 hours for pain, apply one -50 mcg/hr patch topically and change every 72 hours and remove per schedule;
-Administered 11/15/24 at 8:38 A.M. by LPN D;
-Administered 11/18/24 at 1:00 P.M., by LPN A

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	265666	A. BUILDING _____ B. WING _____	R-C 12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWSON MANOR & REHAB	210 WEST 8TH TERRACE LAWSON, MO 64062

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 5	F 610		

-Administered 11/21/24 at 9:50 A.M., by LPN A;
-Administered 11/24/24 at 5:40 P.M. by LPN D;
-Administered 11/27/24 at 8:12 by Registered Nurse (RN) A;
-Administered 11/30/24 at 9:58 A.M. by LPN D
-Administered 12/3/24 at 9:26 A.M. by DON.

Review of progress notes, dated 11/4/24 to 12/5/24, showed:
-On 11/6/24, LPN C wrote resident complained of pain, nurse applied fentanyl patch at 4:00 A.M;
-On 11/7/24, New order entered showed fentanyl transdermal patch 72 hour 50 mcg/HR (fentanyl) controlled drug, apply 1 patch transdermal every 72 hours for pain, apply one 50 mcg/hr patch topically and change every 72 hours and remove per schedule;
-On 11/8/24, LPN D wrote fentanyl 50 mcg patch placed on during morning to upper left back;
-On 11/11/24, LPN B wrote resident fentanyl patch not present on residents back as was reported to this nurse, new patch applied this morning, secured with op-site to right scapula. DON notified.
-On 11/15/24 at 8:21 P.M., LPN B wrote resident was jerking arms and legs spontaneously

During an interview on 12/4/24 at 9:10 A.M., Licensed Practical Nurse (LPN) A said:
-He/She went to check for Fentanyl patch on resident #1 on 11/13/24 and could not find the patch;
-He/She got Certified Medication Technician (CMT) A to go look for patch with him/her and CMT could not locate the patch;

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-He/She looked in blankets and found the adhesive dressing cover to the patch but could not locate the patch;
-He/She also checked trash in room and could not locate fentanyl patch;
-The patch had last been applied on 11/12/24;
-He/She notified the Director of Nursing that the patch was missing on 11/13/24;

During an interview on 12/4/24 at 11:02 A.M., Director of Nursing (DON) said:
-He/She was made aware by LPN A of Resident #1's fentanyl patch was missing on 11/13/24;
-He/She found transdermal cover to patch but the patch was not located;
-The bed had already been stripped, and he/she assumed it may have ended up in laundry;
-He/She did not do an investigation but guessed she probably should have completed one;
-He/She just spoke with hospice nurse and LPN A verbally to investigate the missing patch;
-He/She did not document anything in regards to his/her verbal investigation;
-After fentanyl patch was found missing on 11/13/24, LPN A started placing patch lower and out of resident's reach;
-He/She did not recall Resident #1's patch to be missing on any other dates;
-He/She did not recall LPN B calling him/her on 11/11/24 regarding Resident #1 having fentanyl patch missing.

During an interview on 12/4/24 at 11:29 A.M., Nurse Aide A said:
-He/She provided cares to Resident #1;
-He/She had not seen Resident #1 without his/her pain patch while providing cares;
-He/She had been told by an overnight employee but was not sure which employee that Resident

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#1's fentanyl patch was missing and had been seen on his/her night stand and to notify nurse if the fentanyl patch had been found;
-In last few weeks Resident #1 had episode of jerking really bad and appeared as if he/she was experiencing pain.

During an interview on 12/4/24 at 12:48 P.M., Nurse Aide B said:
-He/She was aware of Resident #1's fentanyl pain patch cover being found on resident's bed side table but could not remember the specific date.

During an interview on 12/4/24 at 1:18 P.M., Corporate Consultant said:
-He/She expected a full investigation to be completed when the fentanyl patch was found missing;
-He/She expected statements to be gathered, physician to be notified;
-He/She found that his/her facility staff did not do anything in regards to an investigation;
-He/She was not made aware of the missing fentanyl patches until he/she arrived on-site to facility today.

During an interview on 12/4/24 at 2:40 P.M., LPN A said:
-He/She discovered at 10:45 A.M. today that Resident #1 did not have his/her pain patch on;
-He/She went and got the DON to report;
-The DON reported that he/she had placed the fentanyl patch on the resident on12/3/24 because he/she was working as the charge nurse;
-He/She did not have an additional fentanyl patch to replace missing patch today so had to call in a new order;
-The DON told him/her that he/she had to waste a fentanyl patch on 12/2/24 because he/she had

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placed the fentanyl patch on Resident #1 backwards;
-He/She did not notify the physician of the missing patch today or on 11/13/24;
-He/She had to administer as needed pain medication due to not having another patch.

During an interview on 12/4/24 at 3:04 P.M., Administrator said:
-He/She expected an investigation to be completed when a fentanyl patch was found to be missing off a resident;
-He/She would have expected the investigation to be documented;
-The DON had not informed him/her about the missing fentanyl patch on 11/11 or 11/13;
-He/She had not been made aware of the missing fentanyl patch until today;
-He/She would have expected the physician to be notified.

During an interview on 12/4/24 at 3:35 P.M., DON said:
-He/She became aware of missing fentanyl patch this morning by LPN A;
-He/She was not able to locate patch;
-He/She discovered resident's bed had been stripped;
-He/She did check laundry but was not able to locate the missing fentanyl patch;
-He/She contacted the physician's group who referred him/her to hospice about the missing patch;
-He/She spoke with hospice and looking at a different narcotic for resident due to the ongoing missing fentanyl patches.

MO245460

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F 728	Continued From page 9	F 728		
F 728 SS=E	Facility Hiring and Use of Nurse Aide CFR(s): 483.35(d)(1)-(3) §483.35(d) Requirement for facility hiring and use of nurse aides- §483.35(d)(1) General rule. A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless- (i) That individual is competent to provide nursing and nursing related services; and (ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154; or (B) That individual has been deemed or determined competent as provided in §483.150(a) and (b). §483.35(d)(2) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section. §483.35(d)(3) Minimum Competency A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual- (i) Is a full-time employee in a State-approved training and competency evaluation program; (ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or (iii) Has been deemed or determined competent	F 728		

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F 728	Continued From page 10	F 728		

as provided in §483.150(a) and (b).
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure six nurse aides (NA) completed a competency evaluation program approved by the state within four months of hire. The facility census was 46.

The facility did not provide an NA certification policy.

Review of the NA employee list showed:
-NA A employed since 6/24/24;
-NA B employed since 4/26/24;
-NA C employed since 7/15/24;
-NA D employed since 7/16/24;
-NA E employed since 6/7/24;
-NA F employed since 2/12/24.

During an interview on 12/4/24 at 11:29 A.M., NA A said:
-He/She was not enrolled in any Certified Nurse Aide class;
-He/She had worked in facility since July 2024, and worked in facility last year from July 2023-November 2023.

During an interview on 12/4/24 at 12:48 P.M., NA B said:
-He/She was not enrolled in CNA class after working for the facility for six months;
-He/She was told several times that he/she would be put in the next CNA class but has never been enrolled in any class.
During an interview on 12/4/24 at 1:40 P.M., NA F said:
-He/She had worked in the facility for 10 months and had not been enrolled in CNA class;

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F 728	Continued From page 11 During an interview on 12/4/24 at 2:40 P.M., Licensed Practical Nurse (LPN) A said: -He/She was concerned that facility had a limited number of CNAs, and that he/she was often left with only NA's who could work. During an interview on 12/4/24 at 3:04 P.M., Administrator said: -He/She expected the Director of Nursing (DON) to ensure competency of facility nurse aides; -Certified Nurse Assistance training was being offered at their sister facility; -NA A, NA B, NA C, NA D, NA E, NA F had not been enrolled in class, but would be scheduled to start CNA class in January 2025. During an interview on 12/4/24 at 3:30 P.M., DON said: -He/She was responsible for nurse aide competencies; -Facility had an operational change and had not gotten nurse aides enrolled in class; -He/She had nurse aides scheduled to be enrolled in next class being offered at sister facility in January.	F 728		
	MO245460			
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		

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F 880	Continued From page 12 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880		

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F 880	Continued From page 13	F 880		

disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on record review, the facility failed to ensure staff provided care in a manner to prevent infection when the facility failed to ensure the required two step tuberculosis (TB, a communicable disease that affects the lungs characterized by fever, cough, and difficulty in breathing) screening test was administered upon hire for six sampled newly hired employees. The facility census was 46.

Review of facility policy, employee screening for tuberculosis, revised March 2021, showed:
-All employees are screened for latent tuberculosis infection and active TB disease, using tuberculin skin test (TST) or interferon gamma release assay (IGRA) and symptom screening prior to beginning employment.
-Newly hired employee is screened for LTBI and active TB disease after an employment offer had

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F 880	Continued From page 14	F 880		

been made but prior to employee's duty assignment.

Observation on 12/4/24 at 1:00 P.M. showed Director of Nursing (DON) could not locate requested employee sample of TB tests for the following employees:
-Dietary Aide A, date of hire 10/17/24;
-Certified Nurse Aide (CNA) A, date of hire 10/16/24;
-Nurse Aide (NA) G, date of hire 10/11/24;
-NA H, date of hire 10/24/24;
-NA I, date of hire 11/6/24;
-Certified Medication Technician (CMT) A, date of hire 11/17/24.

During an interview on 12/4/24 at 1:20 P.M., Director of Nursing (DON) said:
-He/She could not locate TB tests of sampled employees including Dietary Aide A, CNA A, NA G, NA H, NA I, and CMT A;
-TB testing should be completed upon hire;
-The TB testing process fell a part when he/she stopped doing the hiring;
-He/She did not follow up to ensure TB testing was being completed on all new hires.

During an interview on 12/4/24 at 3:04 P.M., Administrator said:
-He/She expected TB testing to be completed before employee starts employment;
-He/She expected documentation of the TB testing to be maintained by the facility.

MO245460

Missouri Department of Health and Senior Services

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	07395	A. BUILDING: _____ B. WING _____	R-C 12/04/2024

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A4023	19 CSR 30-85.042(21)(A) NA Training Complete In 4 mos All nursing assistants shall successfully complete the entire basic course (including passing the final examination) of the nursing assistant training program and be certified within four (4) months of employment. II/III This regulation is not met as evidenced by: Class II 1. Please refer to F728 MO245460 * The higher classification merited due to the extent of the violation.	A4023	Refer to F728	12/20/24
A4031	19 CSR 30-85.042(27) Communicable Disease-Employees The facility must develop and implement policies and procedures which ensure employees are screened to identify communicable diseases and ensure that employees diagnosed with communicable diseases do not expose residents to such diseases. The facility's policies and procedures must comply with the Missouri Department of Health's regulations pertaining to communicable diseases, specifically 19 CSR 20-20.010 through 19 CSR 20-20.100, as amended. II This regulation is not met as evidenced by: Class II 1. Please refer to F880	A4031	Refer to F880	12/20/24

Missouri Department of Health and Senior Services
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Frances Williams

TITLE: Administrator

(X6) DATE: 12/07/2024

Missouri Department of Health and Senior Services

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A4031	Continued From page 1 MO245460	A4031		
A8023	19 CSR 30-88.010(23) Develop/Implement A/N Policies The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of any resident and misappropriation of resident property and funds, and develop and implement policies that require a report to be made to the department for any resident or to both the department and the Department of Mental Health for any vulnerable person whom the administrator or employee has reasonable cause to believe has been abused or neglected. II/III This regulation is not met as evidenced by: Class III 1. Please refer to F610 MO245460	A8023	Refer to F610	12/20/24

PLAN OF CORRECTION

Provider/Supplier Name:	Lawson manor & rehab
Street Address, City, Zip:	210 W 8th terrace, Lawson, MO 64062
Date of Survey:	12/04/2024

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	This plan of correction is prepared and executed because it is required by the provisions of the state and federal regulations and not because Lawson Manor agrees with the allegations and citations listed on the statement of deficiencies. Lawson Manor maintains that the alleged deficient practices do not, individually and collectively, jeopardize the health and safety of the residents nor are they of such character as to limit our capacity to render adequate care as prescribed by the regulation. This plan of correction shall operate as Lawson Manor's written credible allegation of compliance. By submitting this plan of correction Lawson Manor does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position and Lawson Manor reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding.	
F 610	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident # 1 has received pain medication as per doctors order to maintain comfort. How you will identify other residents having the potential to be affected by the same deficient practice. All residents are at risk of this alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The regional nurse consultant will in-service the administrator and don on the abuse and neglect reporting/investigation policy.	12/20/24

	The regional nurse consultant and/or designee will in-service licensed and registered staff members on the abuse and neglect investigation policy and administration of fentanyl patches by the date of compliance. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. Don will perform audits of fentanyl patch placement on all residents who have fentanyl patches ordered 3 times weekly. And provide additional education as need is noted times 4 weeks, then weekly times 3 weeks. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections achieved are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. Don to report results of audit to QAA committee monthly, then, QAA committee to review monthly and augment review process as necessary to maintain compliance.	
F 728	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. No specific resident listed as having been affected by alleged deficient practice. How you will identify other residents having the potential to be affected by the same deficient practice. No residents experienced any adverse effectsl related to risk of this alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. All nurse aides will be enrolled into a state approved certified nurse aide class by the date of compliance. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.	12/20/24

	The administrator and/or don will enroll any nurse aide into an approved course prior to their 120th day of employment. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections achieved are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. The administrator and/or don will monitor and audit new hires weekly time 4 weeks, then monthly times four weeks, then the Don to report results of audit to QAA committee monthly, then, QAA committee to review monthly and augment review process as necessary to maintain compliance.	
F880	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. No residents were identified with this alleged deficient practice. How you will identify other residents having the potential to be affected by the same deficient practice. All residents are at risk of this alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The don and administrator will be in-serviced by the regional nurse consultant regarding TBST testing policy of new employees. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The business office manager will perform an audit of all new hires to ensure that the 2 step TBST has been completed within the first 21 days of employment. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections achieved are sustained.	12/20/24

	The administrator and/or designee will audit all new hire employee files weekly times 3 weeks then monthly times 3 weeks. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. Don and/or administrator to report results of audit to QAA committee monthly, then, QAA committee to review monthly and augment review process as necessary to maintain compliance.	
A4023	Please refer to F 728	12/20/24
A4031	Please refer to F 880	12/20/24
A8023	Please refer to F 610	12/20/24

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.

Franchise Owner Administrator 12/07/2024