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	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lawson Manor & Rehab	210 West 8th Terrace Lawson, MO 64062

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect one resident (Resident #1) from misappropriation of his/her property, when an employee took the resident's narcotic (highly addictive prescription medication) medication. The facility census was 41. Review of the facility policy titled, Abuse, Neglect, Exploitation, and Misappropriation Prevention Program, dated April 2021, showed:-Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation;-The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives:-Protect resident from misappropriation of property by anyone including, facility staff;-Develop and implement policies and protocols to prevent and identify theft, exploitation, or misappropriation of resident property. Review of Resident #1's electronic medical record on 01/09/2026, showed:-The resident's diagnoses included: Fracture of lower end of right femur, cognitive communication deficit (a difficulty with communication that's caused by an underlying issue with cognition), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing a significant impairment in daily life), osteoarthritis of knee (a chronic degenerative joint disease that causes cartilage in the joints to break down over time). Review of the resident's admission Minimum Data Set (MDS, a federally mandated assessment completed by staff), dated 10/16/25, showed:-The resident had adequate hearing, clear speech;-He/She was able to make self-understood and understood others;-He/She scored 7 on the Brief Interview for Mental Status (BIMS, a structured evaluation aimed at evaluating aspects of cognition in elderly residents), indicating the resident had severely impaired cognition;-He/She had limitations to both arms and both legs and used a wheelchair for mobility;-He/She was dependent on staff for Activities of Daily Living (ADLs), including bathing, dressing, toileting and personal hygiene;-He/She reported moderately rated pain. Review of the resident's comprehensive care plan, dated 01/05/26, showed interventions related to limited mobility related to weakness/activity intolerance, behaviors related to being combative during cares, communication related to aphasia/language impairment, risk for falls, depression, seizure disorder, skin integrity, and chronic pain. Review of the resident's discharge orders from the local hospital, dated 10/02/25 showed an order for oxycodone (a highly addictive pain medication used to treat moderate to severe pain) 5 milligrams (mg) tablet every eight hours as needed for moderate to severe pain. Review of the resident's Physician Order Sheet (POS) dated December 2025 showed an order for Oxycodone 5 mg tablet every four hours as needed for pain. The start date for this order was 11/03/25. Review of the resident's progress notes Registered Nurse (RN) A documented, dated 10/03/25 showed:-RN A documented on 10/03/25 at 10:17 A.M. he/she gave the resident scheduled pain medication;-When he/she raised the head of the bed, the resident yelled out in pain;-RN A told the resident the pain medication would take about an hour to work;-When RN A returned to the resident, the resident said the pain was still really bad;-The resident had a (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
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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	new order for oxycodone as needed;-RN A removed three tablets from the emergency kit, one dose was given to the resident;-At 02:47 P.M., RN A documented the dressing was changed to the resident's surgical site and the resident screamed out in pain;-RN A left a message for Nurse Practitioner to increase the frequency of the resident's oxycodone to every four hours as needed.Review of progress note completed by RN A, dated 11/03/25 showed: -At 01:38 P.M., The resident yelled out in pain of the right leg and knee;-The resident was given a pain pill approximately four hours ago;-RN A notified the Nurse Practitioner of the resident's pain and received a new order to increase the frequency of the oxycodone to every four hours as needed;-RN A gave the resident an additional pain pill. Review of the facility investigation, dated 12/22/25 showed:-On 12/22/25 at approximately 7:30 A.M., Licensed Practical Nurse (LPN) A reported to the Assistant Director of Nursing (ADON) that he/she believed that a card of Oxycodone for the resident was missing;-LPN A believed there were three cards of the Oxycodone for the resident on 12/19/15, his/her last worked shift;-When LPN A looked in the narcotic count book, he/she noticed the page for the missing card of oxycodone was folded over, something staff do if the medication card was empty or destroyed;-There was nothing written on the sheet to indicate where the card was;-The ADON notified the Director of Nursing (DON) regarding the missing card of Oxycodone;-The DON verified with the pharmacy that three cards of oxycodone tablets, 180 tablets in total, had been delivered to the facility on [DATE] for the resident; -On 01/06/26 at approximately 07:00 A.M., LPN B notified the ADON and DON that RN A reported to work for the day shift and was not acting right, as if he/she was under the influence;-The DON arrived at the facility to speak with RN A;-RN A pulled the DON into the beauty shop and was not making sense while speaking with the DON;-The DON asked the ADON to assume RN A's duties;-RN A spoke with the DON and Administrator;-During this conversation, both the DON and Administrator determined RN A did not appear to be able to safely and competently work his/her shift at the home;-The DON asked RN A if he/she had taken the missing card of the resident's Oxycodone and RN A said he/she did take the missing card and had folded over the narcotic page to appear as if the medication was gone;-RN A was terminated from employment on 01/06/26. Review of the facility's emergency medication kit medication removal documentation book on 01/09/26 showed on 10/03/25 at 10:03 A.M., RN A signed out three 5mg tablets of Oxycodone and indicated the medication was going to be given to the resident.Review of the resident's 10/25 Medication Administration Record (MAR) on 01/09/26 showed RN A administered one 5mg tablet of oxycodone to the resident on 10/03/25 at 10:30 A.M. There was no documentation in the resident's electronic medical record of the disposition of the other two tablets of Oxycodone that were removed from the emergency medication kit. During an interview on 1/13/26 at 2:15 P.M., LPN A said:-He/She worked on 12/19/25 during the day shift;-On that day, there were three cards of Oxycodone for the resident in the narcotic box with one card being used and two cards that were sent as back up from the pharmacy; -When he/she returned to work on 12/22/25, LPN A completed the narcotic count with the off going nurse, LPN C;-At that time, LPN A noticed there were only two cards of oxycodone for the resident;-LPN A and LPN C looked at the narcotic count sheet and saw the page for the missing card of Oxycodone was folded over, which staff do when a medication was to be destroyed or returned to pharmacy;-There was nothing documented on the sheet;-LPN A notified the ADON of the missing card of Oxycodone.During an interview on 1/13/26 at 12:01 P.M., LPN B said:-On 01/06/26, LPN B worked with RN A and RN A acted bizarre;-LPN B notified the ADON who was the manager on call of RN A's behavior. During an interview on 1/13/26 at 2:25 P.M., the Nurse Practitioner (NP) said:-The only correspondence from the staff at the home he/she received regarding the resident occurred on 10/19/25, notifying him/her of orders for controlled substances needed signed;-The NP did not give the any staff at the home an order to (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	increase the frequency of the resident's Oxycodone;-He/She was never notified the resident had uncontrolled pain or yelling out in pain. During an interview on 1/13/26 at 2:40 P.M., the pharmacy representative said three cards of 5 mg Oxycodone tablets, 180 tablets total, were delivered to the facility on [DATE] and were signed for by LPN C. During an interview on 1/14/26 at 1:10 P.M., the DON said:-Facility nurses should count controlled substances at shift change, the on-coming and off-going nurse together;-They should count each medication cart for each hall;-The card count book should match the count of medications;-Nurses should count each number of pills with each card, and it should match the narcotic count sheets;-The nurses should then sign the sheet at the front of the narcotic count book;-Staff should be counting medications each time the medication room keys change hands as well; -If any medications are found to be missing, all staff will stay at the facility;-The DON will be notified, and an investigation will begin;-The on-coming nurse and off-going nurse will go for a drug test;-The Administrator and Regional Nurse Consultant will be notified of the missing medications;-He/She expected staff will not misappropriate resident medications. During an interview on 1/14/26 at 1:10 P.M., the Administrator said:-He/she expects staff to follow the facility's policy on counting controlled substances.-Missing medications should be reported to the state survey agency.-He/She expected staff will not misappropriate resident medications. Intake 2709249

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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** Based on interview and record review, the facility failed to report Resident #1's missing narcotic (a highly addictive medication) medication to the state survey agency within the required time frame. This deficient practice affected one of four sampled residents. The facility census was 41. Review of the facility's Abuse Investigation and Reporting policy, dated July 2017, showed:-All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state, and federal agencies (as defined by current regulations) and thoroughly investigated by facility management; -All alleged violations, including misappropriation of property will be reported by the facility Administrator, or designee, to the State licensing and certification agency; -An alleged violation of misappropriation of resident property, will be reported immediately but not later than two hours if the alleged violation involves abuse or has resulted in serious bodily injury; or twenty-four hours if the alleged violation does not involve abuse and has not resulted in serious bodily injury; -The Administrator, or designee, will provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation withing five working days of the occurrence of the incident; -Appropriate professional and licensing boards will be notified when an employee is found to have committed abuse.Review of Resident #1's electronic medical record on 01/09/2026, showed the resident's diagnoses included: Fracture of lower end of right femur, cognitive communication deficit (a difficulty with communication that's caused by an underlying issue with cognition), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing a significant impairment in daily life), osteoarthritis of knee (a chronic degenerative joint disease that causes cartilage in the joints to break down over time). Review of the resident's admission Minimum Data Set (MDS, a federally mandated assessment completed by staff), dated 10/16/25, showed:-The resident had adequate hearing, clear speech;-He/She was able to make self-understood and understood others;-He/She scored 7 on the Brief Interview for Mental Status (BIMS, a structured evaluation aimed at evaluating aspects of cognition in elderly residents), indicating the resident had severely impaired cognition;-He/She had limitations to both arms and both legs and used a wheelchair for mobility;-He/She was dependent on staff for Activities of Daily Living (ADLs), including bathing, dressing, toileting and personal hygiene;-He/She reported moderately rated pain. Review of the resident's comprehensive care plan, dated 01/05/26, showed interventions related to limited mobility related to weakness/activity intolerance, behaviors related to being combative during cares, communication related to aphasia/language impairment, risk for falls, depression, seizure disorder, skin integrity, and chronic pain. Review of the resident's discharge orders from the local hospital, dated 10/02/25 showed an order for oxycodone (a highly addictive pain medication used to treat moderate to severe pain) 5 milligrams (mg) tablet every eight hours as needed for moderate to severe pain. Review of the resident's Physician Order Sheet (POS) dated December 2025 showed an order for oxycodone 5 mg tablet every four hours as needed for pain. The start date for this order was 11/03/25. Review of the resident's progress notes Registered Nurse (RN) A documented, dated 10/03/25 showed:-RN A documented on 10/03/25 at 10:17 A.M. he/she gave the resident scheduled pain medication;-When he/she raised the head of the bed, the resident yelled out in pain;-RN A told the resident the pain medication would take about an hour to work; -When RN A returned to the resident, the resident said the pain was still really bad;-The resident had a new order for oxycodone as needed;-RN A removed three tablets from the emergency kit, one dose was given to the resident;-At 02:47 P.M., RN A documented the (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dressing was changed to the resident's surgical site and the resident screamed out in pain;-RN A left a message for Nurse Practitioner to increase the frequency of the resident's oxycodone to every four hours as needed.Review of progress note RN A documented, dated 11/03/25 showed: -At 01:38 P.M., The resident yelled out in pain of the right leg and knee;-The resident was given a pain pill approximately four hours ago;-RN A notified the Nurse Practitioner of the resident's pain and received a new order to increase the frequency of the oxycodone to every four hours as needed;-RN A gave the resident an additional pain pill. Review of the facility investigation, dated 12/22/25 showed:-On 12/22/25 at approximately 7:30 A.M., Licensed Practical Nurse (LPN) A reported to the Assistant Director of Nursing (ADON) that he/she believed that a card of oxycodone for the resident was missing;-LPN A believed there were three cards of the oxycodone for the resident on 12/19/15, his/her last worked shift;-When LPN A looked in the narcotic count book, he/she noticed the page for the missing card of oxycodone was folded over, something staff do if the medication card was empty or destroyed;-There was nothing written on the sheet to indicate where the card was;-The ADON notified the Director of Nursing (DON) regarding the missing card of oxycodone;-The DON verified with the pharmacy that three cards of oxycodone tablets, 180 tablets in total, had been delivered to the facility on [DATE] for the resident; -On 01/06/26 at approximately 07:00 A.M., LPN B notified the ADON and DON that RN A reported to work for the day shift and was not acting right, as if he/she was under the influence;-The DON arrived at the facility to speak with RN A;-RN A pulled the DON into the beauty shop and was not making sense while speaking with the DON;-The DON asked the ADON to assume RN A's duties;-RN A spoke with the DON and Administrator;-During this conversation, both the DON and Administrator determined RN A did not appear to be able to safely work his/her shift at the home;-The DON asked RN A if he/she had taken the missing card of the resident's oxycodone and RN A said he/she did take the missing card and had folded over the narcotic page to appear as if the medication was gone;-RN A was terminated from employment on 01/06/26. Review of the facility's emergency medication kit medication removal documentation book on 01/09/26 showed on 10/03/25 at 10:03 A.M., RN A signed out three 5mg tablets of oxycodone and indicated the medication was going to be given to the resident.Review of the resident's 10/25 Medication Administration Record (MAR) on 01/09/26 showed RN A administered one 5mg tablet of oxycodone to the resident on 10/03/25 at 10:30 A.M. There was no documentation in the resident's electronic medical record of the disposition of the other two tablets of oxycodone that were removed from the emergency medication kit. During an interview on 1/13/26 at 2:15 P.M., LPN A said:-He/She worked on 12/19/25 during the day shift;-On that day, there were three cards of oxycodone for the resident in the narcotic box with one card being used and two cards that were sent as back up from the pharmacy; -When he/she returned to work on 12/22/25, LPN A completed the narcotic count with the off going nurse, LPN C;-At that time, LPN A noticed there were only two cards of oxycodone for the resident;-LPN A and LPN C looked at the narcotic count sheet and saw the page for the missing card of oxycodone was folded over, which staff do when a medication was to be destroyed or returned to pharmacy;-There was nothing documented on the sheet;-LPN A notified the ADON of the missing card of oxycodone.During an interview on 1/13/26 at 2:25 P.M., the Nurse Practitioner (NP) said he/she was not notified of the missing medication until 01/13/26. During an interview on 1/13/26 at 2:40 P.M., the pharmacy representative said three cards of 5mg oxycodone tablets, 180 tablets total, were delivered to the facility on [DATE] and were signed for by LPN C. During an interview on 1/14/26 at 1:10 P.M., the DON said he/she expected staff to follow the facility policy regarding reporting missing medications.During an interview on 1/14/26 at 1:10 P.M., the Administrator said:-Missing medications should be reported to the state survey agency within two hours of the medication being noted (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	missing;-Initially, the facility was not sure the resident's medications were missing; -He/She initially thought the medications would be found but the medications were not found; -The missing medications should have been reported to the State Survey Agency when they were noted missing on 12/22/25. Intake 2709249

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interviews, and record review, the facility failed to maintain a safe and effective medication system when staff did not follow facility policies and procedures in counting narcotic medications, a card of oxycodone medication (a highly addictive prescription medication used to treat severe pain), for one resident (Resident #1). Additionally, staff removed multiple doses of oxycodone from the facility's emergency medication kit at one time without the need for all of the doses to be removed from the emergency medication kit. The facility census was 41. Review of the facility policy titled, Controlled Substances, dated November 2022, showed:-The facility was supposed to comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications; -Controlled substances are counted upon delivery;-The nurse receiving the medication, along with the person delivering the medication, must count the controlled substances together;-Both individuals sign the designated controlled substance record; -Controlled substances are separately locked in permanently affixed compartments, except when using single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected;-The charge nurse on duty maintains the keys to controlled substance containers. The director of nursing services maintains a set of back-up keys for all medication storage areas including keys to controlled substance containers. -Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up.-The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following: Records of personnel access and usage, medication administration records, declining inventory records, and destruction/waste/return to pharmacy records; -Nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory count; -The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the director of nursing services; -The director of nursing services documents irreconcilable discrepancies in a report to the administrator;-If a major discrepancy or a pattern of discrepancies occurs, or if there is apparent criminal activity, the director of nursing services notifies the administrator and consulting pharmacist immediately;-The administrator, consultant, pharmacist, and/or director of nursing services determine whether other actions are needed, such as notification of police or other enforcement personnel;-The medication regimen of residents using medications that have such discrepancies are reviewed to assure the resident has received all medications ordered and the goal of therapy is met, such as a resident receiving a pain medication complains of unrelieved pain; -Waste and/or disposal of controlled medication are done in the presence of the nurse and a witness who also signs the disposition sheet; -Disposal methods are used to prevent diversion and/or accidental exposure to controlled or hazardous substances;-Some controlled substances may be stored in the emergency medication supply;-Reconciliation of controlled substances in the emergency supply is conducted at intervals established by the director of nursing services. Review of Resident #1's electronic medical record on 01/09/2026, showed:-The resident's diagnoses included: Fracture of lower end of right femur, cognitive communication deficit (a difficulty with communication that's caused by an underlying issue with cognition), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing a significant impairment in daily life), osteoarthritis of knee (a chronic degenerative joint disease that causes cartilage in the joints to break down over time). Review of the resident's admission Minimum Data Set (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(MDS, a federally mandated assessment completed by staff), dated 10/16/25, showed:-The resident had adequate hearing, clear speech;-He/She was able to make self-understood and understood others;-He/She scored 7 on the Brief Interview for Mental Status (BIMS, a structured evaluation aimed at evaluating aspects of cognition in elderly residents), indicating the resident had severely impaired cognition;-He/She had limitations to both arms and both legs and used a wheelchair for mobility;-He/She was dependent on staff for Activities of Daily Living (ADLs), including bathing, dressing, toileting and personal hygiene;-He/She reported moderately rated pain. Review of the resident's comprehensive care plan, dated 01/05/26, showed interventions related to limited mobility related to weakness/activity intolerance, behaviors related to being combative during cares, communication related to aphasia/language impairment, risk for falls, depression, seizure disorder, skin integrity, and chronic pain. Review of the resident's discharge orders from the local hospital, dated 10/02/25 showed an order for oxycodone (a highly addictive pain medication used to treat moderate to severe pain) 5 milligrams (mg) tablet every eight hours as needed for moderate to severe pain. Review of the resident's Physician Order Sheet (POS) dated December 2025 showed an order for oxycodone 5 mg tablet every four hours as needed for pain. The start date for this order was 11/03/25. Review of the resident's progress notes Registered Nurse (RN) A documented, dated 10/03/25 showed:-RN A documented on 10/03/25 at 10:17 A.M. he/she gave the resident scheduled pain medication;-When he/she raised the head of the bed, the resident yelled out in pain;-RN A told the resident the pain medication would take about an hour to work; -When RN A returned to the resident, the resident said the pain was still really bad;-The resident had a new order for oxycodone as needed;-RN A removed three tablets from the emergency kit, one dose was given to the resident;-At 02:47 P.M., RN A documented the dressing was changed to the resident's surgical site and the resident screamed out in pain;-RN A left a message for Nurse Practitioner to increase the frequency of the resident's oxycodone to every four hours as needed.Review of the facility investigation, dated 12/22/25 showed:-RN B, who worked on 12/21/25, said he/she didn't recall how many cards of oxycodone were present at that time;-LPN B, who last worked 12/20/25 and 12/21/25, said he/she recalled seeing two cards of the resident's oxycodone, but could not recall if there were three cards;-RN C, who last worked 12/20/25, said there were three cards of the resident's oxycodone at that time;-LPN C, who worked 12/19/25, 12/20/25 and 12/21/25, said he/she could not recall how many cards were present at that time, but recalled the narcotic count was correct at shift change; -When the DON reviewed the narcotic count book, none of the nurses interviewed that signed the Controlled Drug Count sheet that indicated the nurses had completed the medication count between shift for any of the dates mentioned in their interviews;-When the DON reviewed the narcotic count book, none of the nurses interviewed signed the Controlled Drug Count sheet that indicated the nurses had completed the medication count between shift for any of the dates mentioned in their interviews;-In reviewing the Daily Controlled Substances Audit form, where staff verify the card count is correct, the nurses were signing on the form, but not actually completing the required count;-When medication cards were destroyed, the nurses documented put +1 or -2 but were not initialing who added or subtracted a card or what card was added or subtracted. -Review of the facility's emergency medication kit medication removal documentation book on 1/9/26 showed on 10/3/25 at 10:03 A.M., RN A signed out three 5mg tablets of Resident #1's oxycodone.Review of Resident #1's October 2025 Medication Administration Record (MAR) on 1/9/26 showed:-RN A administered one 5mg tab of oxycodone to Resident #1 on 10/3/25 at 10:30 A.M. -There is no documentation in the resident's electronic medical record of the disposition of the other two tablets of Oxycodone that were removed from the emergency medication kit. During an interview on 1/13/26 at 2:15 P.M., LPN A said:-He/She worked on 12/19/25 (continued on next page)

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	during the day shift;-On that day, there were three cards of oxycodone for the resident in the narcotic box with one card being used and two cards that were sent as back up from the pharmacy; -When he/she returned to work on 12/22/25, LPN A completed the narcotic count with the off going nurse, LPN C;-At that time, LPN A noticed there were only two cards of oxycodone for the resident;-LPN A and LPN C looked at the narcotic count sheet and saw the page for the missing card of oxycodone was folded over, which staff do when a medication was to be destroyed or returned to pharmacy;-There was nothing documented on the sheet;-LPN A notified the ADON of the missing card of oxycodone;-He/She said the nurses should always count the narcotic medication/controlled substances at change of shift and make sure the counts match the narcotic count book;-Normally, LPN A would remove multiple doses at one time from the emergency medication kit;-He/She had been trained by other nurses at the facility to do it this way. During an interview on 1/13/26 at 12:01 P.M., LPN B said:-On-going and off-going nurses should count the controlled substances/narcotic medication together and make sure all the counts match with the narcotic count sheet;-When taking medication from the emergency medication kit, the number of doses removed would depend on if it was a weekend and the pharmacy wouldn't deliver the medications until Monday, or any other reason the medication wouldn't be available for a while;-LPN B would remove multiple doses at one time, maybe eight or nine, then write on the emergency kit notebook how many tablets were taken out;-If all the medication was not used by the end of the shift, the staff would include these removed doses in the narcotic count; -LPN B did not know this was not an acceptable way to do this, because he/she was trained by other nurses at the facility to do it this way. During an interview on 1/14/26 at 1:10 P.M., the DON said:-Facility nurses should count controlled substances at shift change, the on-coming and off-going nurse together;-They should count each medication cart for each hall;-The card count book should match the count of medications;-Nurses should count each number of pills with each card, and it should match the narcotic count sheets;-The nurses should then sign the sheet at the front of the narcotic count book;-Staff should be counting medications each time the medication room keys change hands as well; -Staff should only remove one dose at a time from the emergency medication kit, as the medication is needed;-It should be documented in the carbon notebook for the emergency kit and faxed to the pharmacy. During an interview on 1/14/26 at 1:10 P.M., the Administrator said he/she expected staff to follow the facility's policy on counting controlled substances, including removing only one dose from the emergency medication kit at a time. Intake 2709249