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	12/04/2024

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 47195 Refer to Event ID NI0V12. 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.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. 47195 Refer to Event ID NI0V12. 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.

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	265666	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 47195 Refer to Event ID NI0V12. 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.