

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265666	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2025
NAME OF PROVIDER OR SUPPLIER Lawson Manor & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed protect one sampled resident's (Resident #1) right to be free from physical abuse when Resident #2 grabbed Resident #1 by his/her arms and pushed him/her backwards causing Resident #1 to fall and sustain a skin tear approximately 3 inches in length to the underside of the resident's left arm. The facility census was 44. On 7/30/25, the Administrator was notified of the past noncompliance which began on 7/23/2025. The facility administration immediately conducted an investigation and corrective actions were implemented. The noncompliance was corrected on 7/28/25. Review of the facility's Abuse Policy, revised April 2021., showed: -The residents have the right to be free from abuse. -The facility's abuse, policy consists of a facility-wide commitment and resource allocation to support protecting residents from abuse, from other residents, staff, or any individual. -The facility will develop and implement policies and protocols to prevent and identify abuse or mistreatment of residents. - Ensure adequate staffing and oversight. -Provide staff orientation and training programs to include abuse prevention and the management of verbally or physically aggressive resident behaviors. 1. Review of Resident #1's admission face sheet., showed: The resident resided on secured memory care unit. Diagnoses included: Alzheimer's dementia, history of spinal fractures, and weakness. Review of Resident #2's admission face Sheet showed the resident was a new admission as of 7/3/25 with a diagnoses of severe dementia, and delusional disorders. The resident was under guardianship, and resided on the secured memory unit. Observation of the resident on 7/30/25 at 2:25 P.M., showed resident lying in bed, awake with significant confusion, not alert to surroundings or self. Left underside of forearm showed a healing skin tear approximately 3 inches in length. Resident was unable to explain how it happened. Review of Resident #1's Nursing Progress notes., showed that on 7/23/25 around 2:14 P.M. resident was found sitting on the floor in the hallway with legs out in front of him/her. Resident #1 sustained a skin tear when resident #2 pushed resident backwards out of his/her room. Resident #2 admitted to removing the resident out of his/her room. Resident #1's skin tear was treated with triple antibiotic ointment and a Band-Aid, family and physician had been notified. Review of the facility's abuse investigation report dated 7/28/25, showed the abuse of the resident occurred on 7/23/25, the report does not have a time indicated as to when it happened. The resident was identified as independent with ambulation and had been ambulating on 7/23/25 on the hallway of the secured unit. The resident entered into Resident #2's room, and Resident #2 placed his/her hands on Resident #1 and guided the resident backwards out of the room's doorway causing Resident #1 to fall and sustained a skin tear to left arm. Resident #2 reported that Resident #1 should not have been in his/her room. Resident #1 was treated for the skin tear and Resident #2 was placed on 1:1 monitoring (one staff person is assigned to monitor the resident continually). No witnesses were indicated on the facility investigation report. A Velcro stop sign was placed on Resident #2's door to detour Resident #1 from entering Resident #2's room again. During an interview on 7/30/25 at 11:30 A.M., CNA-A said on 7/23/25 he/she heard resident #2 yelling down the hall, and saw resident #1 on the floor. Resident #1 had a new skin tear to the left arm. CNA-A called for the nurse. Resident #2 was cussing and yelling and punching his fists and shaking them at people. CNA A said resident #2 had a short fuse and can become agitated and aggressive easily. Resident #2 was placed on 1:1 monitoring on 7/23/25 after resident #1 was picked up off the floor. CNA A reported that Resident #2 had to be sent out to the hospital earlier in the month for hitting, kicking at staff, and threatening others on the unit. CNA A stated he/she had not received any training on how to de-escalate resident #2's behaviors. Observation on 7/30/25 at 1:11 P.M., showed the resident up and independent with ambulation on the secured memory unit walking closely next to others on the hall. He/she was alert, with extreme confusion, and an unsteady gait. Velcro stop sign hanging off the door frame and not up to detour confused resident's on the memory care unit from wondering into the resident #2's room. Review of resident's nursing progress note records showed that on 7/3/25 day of admission resident was verbally abusive towards others, using foul language and exit seeking. Then, 2 days later on 7/5/25 at 10:32 A.M., the resident was verbally abusive, screaming at staff, slamming doors continually, and frightening other residents. Local law enforcement was called and arrived at the facility around 10:40 A.M., resident begun hitting, kicking, and punching at law enforcement. The resident was removed from the facility in hand cuffs and taken to local ER (Emergency Room) for a mental health evaluation. On 7/6/25 the resident was returned to the secured unit at the facility with new order for prescription Seroquel (an anti-psychotic used to treat behaviors). On 7/13/25 nursing notes showed that the resident was agitated, belligerent, verbally</p>		