

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 08/18/2025
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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(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	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect Resident#1's right to be free from abuse when he/she was choked around the neck by another resident (Resident #2) causing redness to Resident #1's neck and Resident #1 feared Resident #2. Facility census was 48. Review of the facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy, dated April 2021, showed:-Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms; The resident abuse, neglect, and exploitation prevention program consists of a facility-wide commitment resource allocation to support the following objectives: -Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, and/or any other individual; -Develop and implement policies and protocols to prevent and identify: abuse or mistreatment of residents, neglect of residents, theft/exploitation/misappropriation of resident property; -Implement measures to address factors that may lead to abusive situations, for example: adequately prepare staff for caregiving responsibilities. Review of the facility's Resident Rights policy, dated February 2021, showed Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents' rights to be free from abuse, neglect, misappropriation of property and exploitation. 1. Review of Resident # 1's electronic medical record showed:-The resident was admitted to the facility on [DATE];-Diagnoses included: Depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in life), anemia (the blood doesn't have enough health red blood cells and hemoglobin, a protein found in red blood cells, to carry oxygen through the body), dementia (a group of thinking and social symptoms that interferes with daily functioning), anxiety disorder (a mental health disorder characterized by severe, ongoing anxiety that interferes with daily activities), and chronic kidney disease (a longstanding disease of the kidneys, leading to kidney failure). Review of the resident's admission Minimum Data Set (MDS, a federally mandated assessment completed by staff), dated 7/20/2025, showed:-He/She had adequate hearing, clear speech, understands others and makes self understood;-He/She scored nine on the Brief Interview for Mental Status (BIMS, a structured evaluation aimed at evaluating aspects of cognition in elderly residents). This score indicated moderately impaired cognition. Review of the resident's comprehensive care plan, dated 8/18/25, showed: -Interventions related to physical aggression;-He/She had the potential to be physically aggressive to his/her spouse due to diagnoses of dementia, anxiety and depression;-He/She has received physical aggression from his/her spouse, who has been observed with his/her hands around Resident #1's neck;-Staff are to administer medications as ordered and monitor/document behaviors every shift;-Resident #1 was to only have supervised visits with his/her spouse for safety;-Rooming situation is to be re-evaluated as needed. Review of Resident #1's August 2025 progress notes showed the following:-8/3/2025 at 10:00 P.M.: Resident #1 was observed in his/her room laying on the bed. Resident #2 was observed standing over Resident #1 with his/her hands around Resident #1's neck. The residents were separated. After assessment, redness and tenderness were present around Resident #1's neck. He/she rated the pain of 3/10 and refused pain medication; -8/4/2025 at 1:34 P.M.: The administrator conducted an interview with Resident #1 regarding the incident involving Resident #2. Resident #1 stated he/she did not clearly recall the incident. When asked if he/she felt safe sharing a room, Resident #1 responded he/she did feel safe and wishes to share a room. Resident #1 denied any pain or discomfort and stated he/she felt safe at the facility. The administrator spoke with Resident #1's legal guardian, who expressed that if both residents felt safe, the guardian would prefer the residents continue to share a room, noting recent life transitions have already been difficult for them and further separation may lead to increased emotional distress. Resident #1 verbalized relief and happiness upon learning the resident would be allowed to return to the shared room; -8/15/2025 at 1:11PM: Resident #1 was interviewed following an incident involving Resident #2 on 8/15/2025. Resident #1 denied fear of Resident #2 and expressed the desire to continue residing in their shared room. Resident #1 was informed that, for safety, Resident #2 was relocated to a different room at this time. The resident was assessed and found to have no injuries. 2 Review of</p>		