

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265752	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/12/2025
NAME OF PROVIDER OR SUPPLIER  Lawrence County Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  915 Carl Allen Street Mount Vernon, MO 65712	

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.  (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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to ensure all residents were free from misappropriation of property when staff used one resident's (Resident #1) credit card without resident permission and when staff took money from one resident (Resident #2). The facility census was 64. Record review of the facility's policy titled Abuse, undated, defined exploitation as taking advantage of a resident for personal gain, through the use of manipulation, intimidation, threats, or coercion. The same facility policy defined misappropriation as the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. 1. Review of Resident #1's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), completed 08/18/25, showed diagnoses included non-Alzheimer's dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), schizophrenia (a serious mental health condition that affects how people think, feel and behave), depression, and moderately impaired cognition. During an interview 10/30/25, at 2:13 P.M., the resident said the following: -His/her billfold disappeared a few weeks ago. Then credit card charges he/she did not make showed up on a bank statement; -The credit card was always kept in the billfold. The billfold was always kept in the resident's pocket, or in the lock box in the facility business office; -He/she would never give his/her billfold, money, or credit cards to anyone other than his/her family members; -He/she never asked any family to buy anything for him/her at the facility; -He/she had never asked staff to buy anything for him/her; -Prior to the missing billfold and investigation, the resident said he/she didn't know there was a vending machine in the building. During an interview on 10/29/25, at 10:40 A.M., the bookkeeper said suspicious charges were found on the resident's credit card while he/she was assisting the resident with Medicaid information. After requesting bank records for the residents account, the bookkeeper could determine a series of charges made at the facility's vending machine. The charges, all from the vending machine, were on the resident's credit card and dated 08/27/25 through 09/25/25. Total amount charged to the card was approximately \$54.00. Review of the resident's bank records showed 20 charges to the credit card, from the dates of 08/27/25 through 09/24/25. Individual charges were for \$2.65 or \$2.80 and totaled \$55.40. All charges were verified to be from the facility vending machine. During an interview on 10/29/25, at 10:45 A.M., the Administrator said he was able to confirm the former Director of Nursing (DON) had been working at the facility every day a charge was made on the vending machine. Then the Administrator said the facility put up a camera by the vending machine on 09/24/25. On 09/25/25, the camera recorded the former DON using the resident's credit card to make a purchase at the facility vending machine. After watching the video, the Administrator called the police. The police spoke with the former DON and found the resident's credit card in his/her bag. The police then arrested the former DON and took him/her to jail. During an interview on 10/31/25, at 1:09 P.M., the Administrator and the current DON said the former DON had committed misappropriation by using the resident's credit card for her gain and without knowledge of the resident. 2. Record review of Resident #2's quarterly MDS, completed 09/05/25, showed diagnoses included psychosis (including auditory hallucinations) and cognitively intact. Review on 10/29/25, of the facility investigation (related to unauthorized use of Resident #1's credit card by the former DON) showed concerns from the resident about missing cash. The investigation showed the resident said approximately \$16,000.00 was missing. It was cash he/she had given to the former DON for safe keeping. During an interview on 10/30/25, at 12:05 P.M., the resident said the following: -He/she had about \$16,000.00 in cash missing. The cash was from three different checks he/she received as a payout of life insurance for his/her family member. The resident said he/she spoke with only the former DON about different options to cash the checks since the resident did not have any kind of bank account. According to the resident, the former DON had arranged for the Information Technology (IT) Person to take the resident to the bank to cash the checks. The resident said the IT Person took him/her to a bank where the IT Person had an account. The checks had to be put on hold, and they did not come back to the facility with any money the day of the bank visit. The bank visit occurred towards the end of August; -The IT Person came to the facility with \$5,000.00 in cash. The resident took \$500.00 for himself/herself, then asked the IT-person to give the remainder of this cash (\$4,500.00) to the former DON. The resident believed the IT Person did give the cash to the former DON, because he/she confirmed it. The former DON had told the resident he/she had a safe in his/her office and would keep the cash for him/her so that the facility and the State of Missouri (Medicaid) would not take the money from the resident. Review of a facility investigation</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interview, the facility failed to provide pharmaceutical services that assured the accurate acquiring, receiving, and accounting of all drugs when eight cards of narcotics for eight residents (Resident #3, #4, #5, #6, #7, #8, #9 and #10) were found in the former Director of Nursing's (DON's) office desk. The facility census was 64. Review of a facility policy entitled Medications, Narcotics, undated, showed the following:-Narcotics will always be stored under a double lock system;-Each narcotic that the pharmacy dispenses to the facility is accompanied by a narcotic record;-Narcotics will be counted at the beginning and end of each shift by the nurse or CMT ending their shift and the nurse or CMT beginning the shift;-Discontinued narcotics must be pulled from the medication cart and placed in a locked box in the medication room with their narcotic sheets attached Review of a facility policy entitled Medication Storage and Handling, undated, showed the following:-Medications will only be accessible to authorized staff, and in a locked area when not under the direct observation of authorized staff;-Each unit's medication room will remain locked at all times;-The medication cart will always be locked unless it is in direct view of the unit nurse. No medications should be left unattended in resident rooms, on medication carts, at nurse stations;-Medications will be monitored by the unit nurse, charge nurse, and consultant pharmacist to assure that there are no expired, contaminated, or unusable. 1. Review of the facility investigation, dated [DATE], showed the following was found in the office of the former DON's unlocked desk drawer: -Twenty tablets of oxycodone (a narcotic pain reliever) 10 milligram (mg) for Resident #3 with an original order date [DATE];-Thirty tablets of hydrocodone-acetaminophen (a narcotic pain reliever) 5-325 mg for Resident #4 with an original order date [DATE];-Nine tablets of hydrocodone-acetaminophen 10-325 mg for Resident #5 with an original order date of [DATE];-Thirty tablets of hydrocodone-acetaminophen 5-325 mg for Resident #6 with an original order date of [DATE];-Thirty tablets of hydrocodone-acetaminophen 5-325 mg for Resident #7 with an original order date [DATE];-Thirty tablets of hydrocodone-acetaminophen 5-325 mg for Resident #8 with an original order date of [DATE];-Thirty tablets of oxycodone-acetaminophen 10-325 mg for Resident #9 with an original order date [DATE];-Forty-two tablets of Tramadol (a narcotic pain reliever) 50 mg for Resident #10 with an original fill date [DATE]. During an interview on [DATE], at 9:35 A.M., Licensed Practical Nurse (LPN) A said the following:-When medications were running low or there was a change in the dose, the med tech or the nurse will re-order them;-When medications arrived, the nurse signed for them;-When narcotics arrived, the nurse signed for them and added them to the narcotic count;-Staff were to count the narcotics every shift;-To dispose of a narcotic that is no longer needed staff must have two nurses witness;-Narcotics are supposed to be stored behind two locks;-Narcotics are not supposed to be stored in the office, or in the DON's desk;-He/she did not know why narcotics were found in the office. During an interview on [DATE], at 9:43 A.M., Certified Medication Technician (CMT) B said the following:-CMTs pass the scheduled and as needed narcotics;-When he/she got low on a medication they would reorder them from the pharmacy;-When medications arrived, the nurse signed for them and added them to the count;-When a medication was no longer needed, he/she turned them into the nurse;-He/she completed a count of all narcotics before and after their shift;-Narcotics were stored in the narcotic box on the medication cart, ;-Narcotics were always kept behind two locks,-Narcotics were not to be stored anywhere else. During an interview [DATE], at 4:10 P.M., the investigation police officer confirmed the narcotic medications for eight residents was found in a drawer in the former DON's office. The officer said all the found medications were taken by police for an investigation. During interviews on [DATE], at 11:00 A.M. and 1:00 P.M., the interim DON said the following:-Narcotic medications were found in the former DON's office on [DATE],-He/she did not know why the medication was kept in the office,-Narcotics were to be stored in a locked room behind two locks,-Narcotics were not to be stored in any staff members office. During an interview on [DATE], at 1:00 P. M., the Administrator said the following:-On [DATE], management searched the former DON's office and found narcotic medication in his/her desk;-Narcotics were not to be stored in any office. During an interview on [DATE], starting at 1:09 P.M., the Interim DON said narcotic medications should be stored in a locked medication cart, and in a separately locked section for narcotic medications. Complaint 2627589</p>		