STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265752	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lawrence County Manor	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 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. Based on interview and record review, the facility failed to ensure all allegations of possible abuse were reported immediately to management and within two hours to the State Survey Agency (Department of Health and Senior Services - DHSS) when staff received allegations of possible physical abuse by staff involving one resident (Resident #1). Management and DHSS were not made aware of the allegation until the following day. The facility census was 66. Review of the facility policy titled Abuse, undated, showed the following:-The facility will ensure each resident is free from abuse, neglect, misappropriation of resident property, and exploitation;-Every staff member must immediately report any observed or suspected abuse of a resident by another staff member, resident, family member, or visitor;-The Director of Nursing (DON) will ensure all alleged violations are reported immediately, but not later than 2 hours after the allegation is made if the allegations involve abuse or result in serious bodily injury;-The DON will report to the Administrator of the facility and to other officials, including DHSS, not later than 24 hours if the allegations do not involve abuse and result in serious bodily injury.1.Review of Resident #1"s face sheet (a document that gives a resident's information at a quick glance) showed the following:-admission date of 09/14/22;-Diagnoses included hemiplegia (paralysis affecting one side of the body) of the left side, diabetes mellitus, and high blood pressure.Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 12/25/25, showed the following:-Severe cognitive impairment;-No behaviors indicated; -Resident used a wheelchair and dependent on staff for all activities of daily living (ADLs- essential, routine self-care tasks such as, bathing, dressing, toileting, and mobility).Review of the resident's care plan, dated 11/27/25, showed the following:-Resident is dependent on all ADLs;-Resident can be resistive to care at times;-Staff should give clear explanations of all care activities prior to as they occur.During an interview on 01/30/26, at 12:05 P.M. Certified Nurse Aide (CNA) D said the following:-He/she would report any abuse to the charge nurse immediately;-An allegation should be reported to the state within two hours;-On 01/27/26, at approximately 8:00 P.M., CNA B answered a call light in the resident's room;-After leaving the resident's room, CNA B was seen running down the hall with blood on his/her face;-He/she asked the nurse what had happened and was told the resident hit CNA B in the face;-He/she and another CNA went to finish changing the resident;-The resident was not aggressive while he/she provided care;-The resident said he/she did not want that expletive in his/her room anymore;-It was out of character for the resident to hit someone;-The resident said CNA B punched him/her in the stomach and leg;-He/she reported the allegation to the charge nurse (Licensed Practical Nurse (LPN) A); -The charge nurse asked the resident some questions and reported CNA B would not be in the resident's room again.Review of the resident's progress note dated 01/27/26, at 8:30 P.M., showed LPN A documented the resident had the call light on when a staff member went to check on the resident. The resident stated he/she needed to be changed. This writer was passing medication when CNA B reported he/she (the CNA) had (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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a bloody nose and lip. The LPN notified the DON and physician. (The LPN did not document the resident's allegation of possible abuse.)Review of the facility investigation report, dated 01/28/26, showed the following: -The alleged incident occurred 01/27/26 at approximately 8:30 P.M. in the resident's room;-Administration was made aware of the allegation on 01/28/26 at approximately 11:30 A.M.; -Administrator and DON completed a self-report on 01/28/26 at approximately 12:30 P.M.Review of the resident's progress note dated 01/28/26, at 2:28 P.M., showed the Administrator interviewed the resident on 01/28/26, at 12:15 P.M. The resident said CNA B hit him/her in the ribs. The resident then said, quit hurting me or I will poke your eyes out. The resident said CNA B hit him/her a second time on the lower right leg. The resident stated he/she grabbed CNA B's fingers and said, I will get a fork and poke your eyes out.Review of the DHSS records showed the facility self-reported the allegation of abuse to DHSS on 01/28/26 at 12:46 P.M. (16 hours after incident was initially reported to the charge nurse).During an interview on 01/30/26, at 1:00 P.M., LPN A said the following:-He/she would report abuse allegations to the DON immediately;-The state should be notified within two hours;-CNA B came to him/her with a bloody nose and reported the resident punched him/her in the face;-The resident told him/her that CNA B punched him/her in the right leg and that's why he/she hit CNA B in the nose;-The LPN texted the DON and the physician that CNA B hit the resident and had a bloody nose because the resident hit him/her back;-He/she never received a response to the text to the DON or physician;-He/she was unsure of what to do about the incident due to not receiving a response to the text.During an interview on 01/30/26, at 12:00 P.M., LPN C said the following:-He/she would immediately report an allegation to the supervisor;-Abuse should be reported to the state within two hours.During an interview on 02/02/26, at 9:30 A.M., Certified Medication Technician (CMT) E said the following:-He/she would report any abuse to the charge nurse immediately;-The state should be notified of an allegation of abuse within two hours.During an interview on 02/02/26, at 10:30 A.M., LPN F said the following:-He/she would report to the supervisor immediately;-State should be notified of an allegation of abuse in two hours.During an interview on 02/02/26, at 10:45 A.M., CMT G said the following:-He/she would notify the charge nurse of any allegations of right away;-The state should be notified within two hours of an allegation of abuse.During an interview on 02/02/26, at 11:15 A.M., the DON said the following:-The resident reported an employee hit him/her in the ribs during a care plan meeting on 01/28/26;-He/she received a text from staff on the night of 01/27/26, but did not get the text message until after the care conference on 01/28/26; -He/she will educate staff to call and not text her with information;-Staff should report abuse to the DON, Administrator, and state.During an interview on 02/02/26, at 11:30 A.M., the Administrator said the following:-Staff should report abuse immediately to administration;-Abuse should be reported to the state within two hours.Complaint #2729044

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review, the facility failed to timely investigate an allegation of abuse and ensure protection of all residents during the investigation when after receiving an allegation of possible staff physical abuse involving one resident (Resident #1) the staff did not begin an investigation until the next day and allowed the staff member to continue to work with residents independently. The facility had a census of 66. Review of the facility policy titled Abuse, undated, showed the following:-The facility will ensure each resident is free from abuse, neglect, misappropriation of resident property, and exploitation;-The facility will take immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;-The facility will ensure that all alleged violations are thoroughly investigated; -The Director of Nursing (DON) will immediately initiate an abuse incident report and begin investigation of alleged abuse;-The DON will prevent further potential abuse while the investigation is in progress;-Report the results of all investigations to DHSS within five working days of the incident;-The DON or Administrator will reassign or suspend the involved employee at their discretion to protect the residents during the abuse investigation.1.Review of Resident #1"s face sheet (a document that gives a resident's information at a quick glance) showed the following:-admission date of 09/14/22;-Diagnoses included hemiplegia (paralysis affecting one side of the body) of the left side, diabetes mellitus, and high blood pressure.Review of the resident's care plan, dated 11/27/25, showed the following:-Resident is dependent on all activities of daily care (ADLs- essential, routine self-care tasks such as, bathing, dressing, toileting, and mobility);-Resident can be resistive to care at times;-Staff should give clear explanations of all care activities prior to as they occur.Review of the resident's annual Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff), dated 12/25/25, showed the following:-Severe cognitive impairment;-No behaviors indicated; -Resident used a wheelchair and dependent on staff for all ADLs.During an interview on 01/30/26, at 12:05 P.M. Certified Nurse Aide (CNA D) said the following:-On 01/27/26, at approximately 8:00 P.M., CNA B answered a call light in the resident's room;-After leaving the resident's room, CNA B was seen running down the hall with blood on his/her face;-He/she asked the nurse what had happened and was told the resident hit CNA B in the face;-He/she and another CNA went to finish changing the resident;-The resident said he/she did not want that expletive in his/her room anymore; -The resident said CNA B punched him/her in the stomach and leg;-He/she reported the allegation to the charge nurse (Licensed Practical Nurse (LPN) A); -The charge nurse asked the resident some questions and reported CNA B would not be in the resident's room again;-CNA B continued to work the rest of the shift on another hall.Review of the resident's progress note dated 01/27/26, at 8:30 P.M., showed LPN A documented the resident had the call light on when a staff member went to check on the resident. The resident stated he/she needs to be changed. This writer was passing medication when CNA B reported he/she had a bloody nose and lip. DON and physician notified. (The LPN did not document the resident's allegation, beginning an investigation, or steps taken to protect all residents.)During an interview on 01/30/26, at 1:00 P.M., LPN A said the following:-CNA B came to him/her with a bloody nose and reported the resident punched him/her in the face;-The resident told him/her that CNA B punched him/her in the right leg and that's why he/she hit CNA B in the nose;-He/she texted the DON and the physician that CNA B hit the resident and had a bloody nose because the resident hit him/her back;-He/she never received a response to the text to the DON or physician;-CNA B continued to work the rest of the shift but did not work with Resident # 1;-Staff accused of abuse should not have access to a resident after the allegation;-He/she was unsure of what to do about the incident due to not receiving a response to the text.Review of the facility (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	investigation report dated 01/28/26, showed the following: -The alleged incident occurred 01/27/26 at approximately 8:30 P.M. in the resident's room;-Administration was made aware of the allegation on 01/28/26 at approximately 11:30 A.M.;-The Administrator interviewed the resident while the DON and Social Services Director (SSD) performed resident interviews to determine if any other resident had altercations with staff;-LPN C performed a full body assessment on the resident with no bruising or open areas noted to the areas where resident indicated the staff had harmed him.-Staff did not document steps taken to protect all residents immediately after the allegation was made.Review of the resident's progress note dated 01/28/26, at 2:28 P.M., showed the Administrator interviewed the resident on 01/28/26, at 12:15 P.M. The resident said CNA B hit him/her in the ribs. The resident then said, quit hurting me or I will poke your eyes out. The resident said CNA B hit him/her a second time on the lower right leg. The resident stated he/she grabbed CNA B's fingers and said, I will get a fork and poke your eyes out.During an interview on 02/02/26, at 11:15 A.M., the DON said the following:-The resident reported an employee hit him/her in the ribs during a care plan meeting on 01/28/26;-He/she received a text from staff on the night of 01/27/26, but did not get the text message until after the care conference on 01/28/26;-He/she will educate staff to call and not text her with information; -An employee accused of abuse should be suspended immediately pending an investigation.During an interview on 02/02/26, at 11:30 A.M., the Administrator said the following:-CNA B should have been suspended as soon as the allegation was made;-CNA B should not have worked with residents after the abuse allegation was made;-Staff should document everything related to the abuse allegation in a progress note.Complaint #2729044