STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265854	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rest Haven Health Care Center	1800 South Ingram Sedalia, MO 65301

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to ensure one resident (Resident #1) remained free from sexual abuse, when staff found Certified Nurse Assistant (CNA) A in the resident's bed with his/her pants around his/her ankles, resident's pants and underwear off. CNA A admitted he/she sexually assaulted the resident. The facility census was 62.The administrator was notified on 01/06/26 of a past non-compliance immediate jeopardy (IJ) which occurred on 01/04/26. The administrator immediately began an investigation and began in-servicing all staff on abuse and neglect who were on duty and continued in-servicing staff not on duty prior to their shifts. The IJ was corrected on 01/04/26. 1. Review of facility's abuse and neglect policy, revised 06/2024, showed the definition of abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse, including abuse facilitated or enabled through the use of technology. Sexual abuse is non-consensual contact of any type with a resident. Sexual abuse includes, but is not limited to the following:-Unwanted intimate touching of any kind especially of breasts or perineal area;-All types of sexual assault or battery, such as rape, sodomy or coerced nudity;-Forced observation of masturbation and/or pornography. Review of CNA A's employee file showed an abuse and neglect acknowledgement, dated 06/06/24, and signed by the employee. The record contained a Criminal Background Check, dated 12/10/25, which showed the employee eligible to work in a long-term care facility. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 11/14/25, showed staff assessed the resident as non-verbal, and with diagnoses of psychological development disorders (conditions starting in childhood affecting brain function, impacting behavior, learning, language, and movement), intellectual disabilities, and developmental disorder. Review of the resident's nurses' note, dated 01/4/26 at 6:43 A.M., showed Licensed Practical Nurse (LPN) E documented he/she entered the resident's room to give him/her morning medication, and observed CNA A in bed with the resident and did not have pants on. Staff hollered down the hall for assistance as CNA A continued to lay in bed with resident after being asked to leave. Multiple staff responded and CNA A left room at this time. Instructed another staff member to stand and watch over the resident. Review of the resident's nurses' note, dated 01/4/26 at 6:46 A.M., showed Registered Nurse (RN) D documented the day nurse stated he/she went to resident's room to give him/her medication and observed CNA A and the resident both in the resident's bed with no pants on. RN D went to the resident room and CNA A now with pants on and sat on the resident's bed. RN D advised CNA A to leave facility now. 911 called at this time to request police and ambulance. Advised operator that we have a possible assault on a resident discovered by staff. Review of the resident's nurses' note, dated 01/4/26 at 6:52 A.M., showed RN D documented that a message was left for the Director of Nursing (DON) and 911 called (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	at this time to request police and ambulance. RN D advised operator that they had a possible assault on a resident. RN D told the operator an LPN discovered the resident and staff member in the resident's bed with no pants on and they were discovered approximately five minutes ago. RN D told the operator the CNA, who now had on black pants, was sitting on the resident's bed next to the resident, who did not have on pants. RN D documented CNA A was told several times to leave the resident's room and CNA and charge nurse were at the resident's room before CNA decided to leave. RN D documented the operator said police were on the way and to call back if the CNA returns.Review of the resident's nurses' note, dated 01/4/26 at 6:57 A.M., showed RN D documented the CNA had returned to resident room and was sitting on the resident's bed with the resident who was still naked from the waist down. RN D documented the CNA was told to leave the resident's room and police were on the way. RN D documented he/she called 911 again. RN D documented the CNA went to the resident's chair, picked up a black bag and left the room. RN D documented he/she advised 911 the CNA was outside and did not have a vehicle, but might be waiting for a cab or ride service.Review of the resident's nurses' note, dated 01/4/26 at 7:00 A.M., showed RN D documented he/she went to the resident's room to check on the resident and the resident was pulling up his/her black slacks at the time without assistance.Review of the resident's nurses' note, dated 01/4/26 at 7:00 A.M., LPN E documented the CNA standing watch alerted him/her that CNA A returned to the resident room seemingly to get belongings. LPN E responded and CNA A exited resident room again.Review of resident's nurse's note, dated 01/4/26 at 7:05 A.M., showed staff documented police at facility and detained CNA A.During an interview on 01/04/26 at 1:25 P.M., the Assistant Director of Nursing (ADON) said he/she last saw CNA A at the 200-hall nurse station with CNA C around 1:00 A.M. The ADON saw CNA C about 15 minutes later, but CNA A was not with him/her. He/She checked the facility and the facility parking lot and could not locate CNA A. He/She called CNA A's phone sometime after 1:00 A.M. and the phone rang in a bag at the nurses station. The ADON thought CNA A left the facility. The ADON checked on Resident #1 at approximately 1:30 A.M. He/She noticed CNA A's bag was gone from the nurses station at approximately 5:30 A.M. The ADON called his/her phone again and he/she did not answer so he/she thought he/she was gone for the day. He/She did not notify anyone when he/she could not find CNA A earlier because it was the middle of the night, and he/she didn't think anyone would be able to come in and help. He/She just focused on finishing his/her work for the night and gave report at the nurses station at approximately 6:00 A.M. and left the facility During an interview on 01/04/26 at 2:30 P.M., LPN E said he/she came in to work at 6:00 A.M. and he/she took medications to Resident #1 sometime between 6:45 and 6:50 A.M. When he/she went in the resident's room the curtain was drawn which he/she thought was odd for the resident. LPN E pulled the curtain back and saw CNA A and the resident laying on their right sides in bed. LPN E said it appeared the two were having intercourse, but he/she was not sure. LPN E said CNA A's pants were at his/her ankles and the resident's sweatpants and underwear were on the bed. LPN E said CNA A said hi when he/she saw him/her. LPN E called for help and RN D, LPN F, Certified Medication Technician (CMT) G and CNA H came to the 100 hall. LPN E instructed CNA H to stay at the resident's room because CNA A did not want to leave the room. LPN E said CNA A left the room a short time later, then tried to go back in the room. CNA A then went toward the front of the building. LPN E returned to the resident's room to check on the resident and CNA A's phone was on the resident's bed with porn pulled up.During an interview on 01/04/26 at 2:10 P.M., RN D said LPN E notified him/her about 6:52 A.M., saying he/she thought he/she witnessed an assault. LPN E told RN D he/she found CNA A in bed with Resident #1. LPN E told him/her they were both naked from the waist down and CNA A was watching pornography on his/her phone. RN D said when he/she arrived at Resident 1's room CNA A had (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	his/her pants on, and he/she was sitting in bed with the resident. RN D told CNA A to get out of the resident's room. LPN E told him/her to go call the administrator. RN D said he/she called the administrator who instructed him/her to call the police. CNA A came out of the resident's room, wandered a bit and then went back into the resident's room. RN A called 911 again to get the police to the facility faster. RN D said CNA A came out of the resident's room at some point later and went outside the front of the building where he/she was waiting when police arrived. During an interview on 01/04/26 at 2:55 P.M., CNA H said on 01/04 he/she came into work at approximately 6:00 A.M., and was working on getting the 100-hall residents up for the day when LPN E was at the 100-hall nurse station calling to LPN F and CMT G for help. CNA H said he/she went with the LPNs and CMT to the resident's room where CNA A was sitting on the bed with the resident. CNA H said CNA A kept trying to close the resident room door when asked to leave the resident's room. CNA A eventually left the resident's room and went outside the facility and was outside when the police showed up. CNA H said he/she went to the hospital with the resident, where the resident appeared scared. During an interview on 01/04/26 at 3:05 P.M., LPN F said he/she started work a little before 6:00 A.M. on 01/04/26. LPN F said he/she was working on the 200-hall early in the shift when LPN E came to the 200-hall nurse station and said he/she thought he/he saw CNA A in bed with the resident. LPN F said he/she walked with LPN E to the resident's room and other staff were at the room. LPN F said he/she went to the 100-hall nurse station with LPN E where LPN E asked RN D to call the administrator. LPN F said someone told CNA A to leave the resident's room, but CNA A did not leave. LPN F said he/she told CNA A to leave and walked him/her to the front of the building. During an interview on 01/04/26 at 4:40 P.M., the administrator said the resident was in the hospital and CNA A was in police custody. The facility investigation was ongoing and he/she was conducting resident interviews and staff education. During an interview on 01/05/26 at 12:52 P.M., the police officer said he/she and two other officers responded to a call to the facility on [DATE] at approximately 6:40 A.M. The officer said contact was made with CNA A who was standing outside the facility and claimed he/she did not know what was going on. The officer said he/she detained CNA A and other officers obtained witness statements. During an interview on 01/05/26 at 1:00 P.M., the Sexual Assault Nurse Examiner (SANE) RN said he/she was called to the hospital the morning of 01/04/26 to perform a sexual assault exam on the resident. The SANE RN said the resident appeared very timid and was afraid to be touched. The SANE RN said he/she completed an exam to collect evidence which would be submitted to the police department. The SANE RN said he/she could only perform a limited exam since resident was afraid to be touched.During an interview on 01/05/2026 at 1:49 P.M., the detective said he/she read CNA A his/her [NAME] rights on 01/04/26 around noon. The detective said CNA A said he/she had sex with the resident prior to the nurse coming in the room, but they were not having sex when the nurse came in. CNA A told him/her they were watching porn when the nurse came in. CNA said he/she was in the resident's room from 11:00 or 12:00 the night before and he/she had sex with the resident 2 or 3 times before. CNA A told him/her since the resident was in a nursing home it (sex) was part of the resident's DLA which CNA A clarified to mean daily living activities. During an interview on 01/05/2026 at 7:04 P.M., CNA C said he/she worked from 6:00 PM on 01/03/26 to 6 AM on 01/04/26. CNA C said CNA A was working, but he/she did not see him/her after 12:30-1:00 A.M. when he/she saw him/her on the 200 hall. CNA C said he/she could not remember what CNA A was doing on the 200 hall since he/she was assigned the 100-hall. CNA C was responsible for checking on every resident every two hours. The CNA said he/she did not believe he/she entered Resident #1's for the entire shift, because he/she was busy. CNA C said he/she thought facility policy was to check every resident every two hours. The CNA said he/she didn't think anything of not (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	seeing CNA A after 1:00 A.M. since they were assigned different halls. During an interview on 01/06/2026 at 11:38 A.M., the ADON said he/she worked as the charge nurse starting the night of 01/03/26 and ending the morning of 01/04/26. The ADON said the shift started with himself/herself and six other staff. The ADON said two staff members left at approximately 10:00 P.M. as scheduled and another staff member was permitted to leave early at approximately the same time. The ADON said after 10:00 P.M. CNA C was assigned to the 100-hall and CNA A and CNA I were assigned to the 200-hall. The ADON said he/she spoke with the resident at approximately 1:00 A.M. The ADON last saw CNA A at approximately 1:15 A.M. During an interview on 01/06/25 at 7:05 P.M., CNA I said he/she worked the night shift starting on the evening of 01/03 and ending on the morning of 01/04/26. CNA I said the shift started with four CNAs and one nurse. CNA I said one CNA was sent home before midnight, which left three CNAs and one nurse to cover the remainder of the shift. CNA I said he/she was working the 200-hall with CNA A. CNA I saw CNA A at approximately 1:30 A.M. and CNA A was walking toward the front of the building, which included the resident's room. CNA I assumed CNA A was going outside to smoke. in the past CNA A would sometimes disappear for one or two hours, but he/she never told anyone because he/she felt it wasn't his/her place to keep track of a coworker. CNA I said he/she clocked out at approximately 5:15 A.M., which was early. CNA I said he/she clocked out early because he/she was frustrated about having to cover for CNA A all night because he/she had worked the 200 hall alone after 1:00 A.M. when they thought CNA A had quit. During an interview on 01/06/2026 at 2:15 P.M., the administrator said he/she would expect staff to notify the DON if a staff member could not be locatedIncident #2706837Complaint #2706865

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, facility staff failed to store food in a manner to prevent potential contamination and outdated use. Facility staff failed to ensure the dish washing machine operated according to manufacturer's instructions to adequately prevent cross contamination of kitchen wares. Facility staff failed to perform hand hygiene as often as necessary, using approved techniques, to prevent cross-contamination. The census was 64.1. Review of the facility's Resident Food: Storage and Sharing policy, revised 09/16/2024, showed the purpose of the policy is to ensure resident food storage is safe with sanitary storage, handling and consumption. Review showed food items will be dated after opening and prepared food that is dated three days after it is placed in the refrigerator will be discarded.Review of the kitchen policies provided by the facility showed they did not contain a kitchen specific food labeling and storage policy. Observation on 12/30/25 at 12:00 P.M., showed the dry goods storage area contained a service cart with six plastic containers of cereal and six bowls of cereal wrapped in plastic. The cart contained two opened zipped plastic storage bags of cereal without a date.Observation on 12/30/25 at 12:05 P.M., showed the front of the reach in cooler contained a sign which read Every item in this reach in will have an open date on it. No exceptions. Observation showed the reach in cooler contained:-A plastic bag with an unknown white substance unlabeled and undated;-A plastic container covered with plastic wrap which contained a tan gravy appearing substance and the container was dated 11/28; -A plastic container covered with plastic wrap which contained a brown substance and the container was dated 11/28; -An unlabeled and undated plastic container covered with plastic wrap which contained an applesauce appearing substance; -An unlabeled and undated metal container covered with plastic wrap which contained sliced fruit in juice; -Two opened and undated containers of sour cream. The lid of one container had an accumulation of brown liquid and one container lid was soiled with food debris;-A mayonnaise jar opened and undated;-A bottle of key lime juice opened and undated;-An pan of cooked beans with meat undated and partially uncovered;-A large pan of corn bread unlabeled and undated;-A large container of opened and undated pimento spread which contained a black material on the lid and below the lip of the lid;-A container of Italian dressing opened and undated. During an interview on 12/30/25 at 1:35 P.M., [NAME] A said all kitchen staff were responsible for labeling and dating all opened food items. Left over prepared food items should be thrown away after three days. He/She checked food dates in the reach in cooler three days ago. [NAME] A said he/she did not know why the unlabeled or the older food items were still in the cooler.During an interview on 12/30/25 at 1:50 P.M., the administrator said all kitchen staff were responsible for ensuring all opened food items were labeled and dated. Leftovers should be discarded after three days. The dietary manager started a couple months ago, and his/her work schedule had been sporadic. The administrator said he/she was not aware of any food storage issues. 2. Review of the facility's Dietary-Equipment Operations, Infection Control and Sanitation policy, revised 02/02/2024, showed:-Before each use, allow dishwasher to run ten minutes to bring water temperature up to a proper level;-Read temperature gauges on machine while racks are in machine;-Low temperature dishwasher wash temperature 120 to 140 degrees Fahrenheit (F);-Low temperature dishwasher rinse temperature 102 to 150 degrees F;-Any inaccurate temperature must be brought to the attention of the dietary manager immediately. Observation on 12/30/25 at 11:45 A.M., showed the front of the dishwasher contained a placard which indicated minimum wash and rinse temperatures of 120 degrees F.Observation on 12/30/25 at 11:45 A.M., showed Dietary Aide (DA) B ran a load of plates through the dish machine. Observation showed a calibrated digital thermometer indicated the highest water temperature during the wash and rinse cycles was (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	78 degrees F. Observation on 12/30/25 at 12:20 P.M., showed [NAME] A used a food processor to puree cooked spinach and onions. [NAME] A rinsed the processor parts and ran the parts through the dishwasher. Observation showed a calibrated digital thermometer indicated a wash temperature of 78 degrees F and a rinse temperature of 85 degrees F. [NAME] A used the same food processor to prepare different food items, and the processor was not properly sanitized to prepare mechanical soft and pureed breaded pork which was served to residents at the noon meal. Observation on 12/30/25 at 1:45 P.M., showed DA B ran a rack of soiled lunch plates through the dishwasher. Observation showed the highest water temperature indicated on a calibrated digital thermometer was 108 degrees F. During an interview on 12/30/25 at 11:45 A.M., DA B said he/she used the dishwasher to wash resident dishes after the morning meal. DA B said he/she never checked the dishwasher temperature, and he/she did not know what the water temperature should be.During an interview on 12/30/25 at 1:45 P.M., DA C said he/she used the dishwasher and checked sanitizer concentration, but he/she never checked the water temperature.During an interview on 12/30/25 at 1:05 P.M., the maintenance director said the kitchen and laundry maintained hot water during the facility's recent loss of hot water. The maintenance director said he/she checked the kitchen water temperatures a few days ago. The maintenance director said the dishwasher had a water temperature booster and he/she was not aware the machine water was not reaching 120 degrees.During an interview on 12/30/25 at 1:50 P.M., the administrator said the dishwasher water temperature should be above 120 degrees. The administrator was not aware the dishwasher water was not reaching the proper temperature. 3. Review of the facility's Dietary - Sanitary Procedures policy, revised 11/06/2023, showed when gloves are used hand washing must occur per hand washing procedure prior to putting on gloves and whenever gloves are changed. Gloves must be changed as often as hands need to be washed. Review showed hands must be washed prior to beginning work, after using the restroom, after smoking, when working with different food substances and following contact with any unsanitary surface. Observation on 12/30/25 at 12:20 P.M., showed [NAME] A used a food processor to puree cooked spinach and onions. [NAME] A took apart the food processor, rinsed the parts and ran the parts through the dishwasher. [NAME] A then scrubbed soiled pans in the three-part sink. [NAME] A removed his/her gloves and donned (applied) a clean pair of gloves. [NAME] A did not wash his/her hands before donning clean gloves. [NAME] A used his/her gloved hands to reassemble the food processor and used the food processor to prepare mechanical soft and pureed pork for seven residents which was served at the noon meal.Observation on 12/30/25 at 12:30 P.M., showed DA B took a stack of soiled plates from the facility administrator. DA B used a gloved hand to clear remaining food, paper goods, and utensils from the plates. DA B removed his/her gloves and donned a clean pair of gloves and did not wash his/her hands before donning the clean gloves. DA B prepared a peanut butter sandwich with his/her gloved hands. Observation showed a staff member took the sandwich from the kitchen to be served to a resident. During an interview on 12/30/25 at 12:55 P.M., [NAME] A said hands should be washed when going from a dirty task to a clean task or before putting gloves on. [NAME] A said he/she was in a hurry and forgot to wash his/her hands before putting on clean gloves.During an interview on 12/30/25 at 1:45 P.M., DA B said he/she should wash his/her hands before putting on clean gloves. DA B said he/she was busy did not realize he/she didn't wash his/her hands.During an interview on 12/30/25 at 1:50 P.M., the administrator said staff should wash hands after touching dirty items and before putting on clean gloves. The administrator said he/she was not aware kitchen staff were not washing hands when required.