STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265854	A. Building B. Wing	05/12/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interviews and record review, facility staff failed to maintain professional standards of care, when Licensed Practical Nurse (LPN) A administered treatment to one resident's (Resident #1's) burn injury, without obtaining an order from the physician. The facility's census was 53.The administrator was notified on 05/12/26 of past Non-Compliance which occurred on 05/08/26. On 05/07/26, staff were in-serviced on when to notify management of incidents, and to always obtain an order from the physician for treatments, and on 05/08/26, LPN A was in-serviced and counseled on when to obtain orders from the physician for a treatment. 1. Review of the facility's Transcription of Orders/Following Physician's Orders policy, dated 05/18/24, showed the purpose is to ensure that all physician's orders are followed. 2. Review of Resident #1's Quarterly Minimum Data Set (MDS), a federally mandated assessment, dated 03/17/26, showed staff assessed the resident as cognitively intact, and without impairments to hands/arms or legs. Review of the resident's progress note, dated 05/07/26 at 5:49 A.M., showed LPN A documented resident spilled hot water on his/her legs, redness and peeling observed, petroleum ointment applied, will pass on to next shift and continue to monitor for any skin issues that may present. The note did not contain documentation LPN A obtained an order from the physician to apply soothing petroleum. Review of the resident's Physician Order Sheet (POS), dated 05/01/26 through 05/07/26, did not contain documentation for an order to apply petroleum ointment to resident's legs. During an interview on 05/12/26 at 9:56 A.M., LPN B said after he/she took report from LPN A, he/she went to the resident's room, called the wound nurse to assess the resident with him/her, and he/she contacted the resident's physician on 05/07/26 at approximately 7:30 A.M. to obtain an order to treat the burn injury to resident's legs. During an interview on 05/12/26 at 11:45 A.M., LPN A said the resident spilled hot water on his/her legs which resulted in a burn injury. LPN A said he/she cleaned up the hot liquid from the resident's legs and applied a petrolatum ointment to the burn areas and passed on to the oncoming nurse what he/she had done. LPN A said he/she did not obtain a treatment order from the physician. LPN A said he/she was re-educated on the facility's policy to always contact the physician and obtain an order prior to administering any treatments. During an interview on 05/12/26 at 1:32 P.M., the Director of Nursing (DON) said he/she would expect the nurse to obtain an order from the physician and follow the orders for treatment. During an interview on 05/12/26 at 3:05 P.M., Nurse Practitioner C said he/she would expect the nurse to initially administer a cold compress to the burn injury, assess for pain, and contact him/her for a treatment order. Nurse Practitioner C said applying petrolatum ointment to the resident's skin was not an appropriate treatment for the nurse to administer to the resident's burn injury. During an interview on 05/12/26 at 3:20 P.M., the administrator said if a resident is injured, his/her expectation is for the nurse to contact the physician to obtain an order for treatment and follow the orders. Intake # 3007759

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, facility staff failed to ensure one resident (Resident #1) remained free from accidents, when Licensed Practical Nurse (LPN) A heated water in a microwave and gave it to the resident, the resident spilled the hot water on him/herself, which resulted in a burn injury to the resident's legs. Facility staff failed to prevent one resident (Resident #2) from falling, when staff assisted the resident with one staff member and rolled the resident to his/her side during care and the resident fell from his/her bed. The facility's census was 53.The administrator was notified on 05/12/26 of past Non-Compliance which occurred on 05/08/26. On 4/17/26, the nursing staff were in-serviced on the facility's Fall Prevention and Safe Resident Handling policies, and on 05/07/26 to 05/08/26, staff were in-serviced on abuse and neglect, how to heat foods/liquids for residents and safe temperatures to serve hot liquids to residents. 1. Review of the facility's policies showed the facility did not provide a policy for how to assess a resident for safety with hot liquids. Review of the facility's Dietary Food Preparation policy, dated 07/05/23, showed foods will be served at proper temperature to ensure food safety, and acceptable serving temperatures for coffee is >135 degrees Fahrenheit (F). 2. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment, dated 03/23/26, showed staff assessed the resident as cognitively intact, without impairment to his/her hands/arms, and independent with eating. Review of the facility's investigation, dated 05/07/26, showed staff documented the resident sustained a burn injury, staff assessed the resident, treatment orders were obtained from the physician, staff were in-serviced on the process to heat foods/liquids for residents, safe temperatures to serve hot liquids to residents, and all microwaves were removed from residents and staff accessible areas. Review of the resident's care plan, revised 05/07/26, showed staff documented the resident prefers to have his/her coffee extremely hot. The care plan did not contain interventions to direct staff on how to provide hot liquids to residents. Review of the resident's progress notes, dated 05/07/26 at 5:49 A.M., showed LPN A documented he/she heated water in a cup, per resident's request to make instant coffee in his/her room, secured the lid to the cup for safety, and handed the cup to the resident. The resident removed the lid from the cup and spilled the hot water on his/her legs, redness and peeling was observed, petroleum ointment was applied, will pass on to next shift and continue to monitor for any skin issues that may present. Review of the resident's progress notes, dated 05/07/26 at 7:31 A.M., showed staff documented resident has burns to both upper legs, orders received to apply a topical antimicrobial medication used to prevent and treat infection in second and third-degree burns twice daily. Review of the resident's Physician's Orders, dated 05/07/26, showed an order to apply a topical antimicrobial medication to both upper legs every morning and at bedtime for burn, apply non-adherent dressing to large areas and cover with a self-adherent wrap to secure dressing, and an order to administer one Bactrim DS (an antibiotic) 800-160 milligram tablet by mouth every morning and at bedtime for five days as prophylaxis for burn. Observation on 05/12/26 at 12:15 P.M., showed the resident with a bandage to both his/her legs. During an interview on 05/12/26 at 11:45 A.M., LPN A said the resident took his/her cup with water to the microwave area and asked staff to heat the water for him/her. LPN A said he/she heated the water in the microwave for about a minute, placed the lid on the cup, gave the cup to the resident, told the resident it was hot and to wait a few mins before removing the lid. LPN A said the resident spilled the hot water on his/her legs which resulted in a burn injury. During an interview on 05/12/26 at 12:15 P.M., the resident said he/she asked staff to heat water for him/her to make instant coffee in his/her room. The resident said LPN A gave him/her the cup of hot water with the lid on, told him/her it was hot and to wait a few minutes, but he/she was eager to make the coffee and when he/she tried to remove the lid from the cup, he/she spilled the hot water on his/her legs. The resident said, I like my coffee hot, who doesn't? During an interview on 05/12/26 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	at 1:32 P.M., the Director of Nursing (DON) said as a safety precaution, he/she would expect staff to ensure they do not serve residents hot liquids above 120 degrees F, and thermometers are in the kitchen for use. During an interview on 05/12/26 at 3:05 P.M., Nurse Practitioner C said staff contacted him/her around 7:30 A.M. regarding the burn injury and he/she gave an order for a topical antibiotic cream. Nurse Practitioner C said he/she assessed the resident about an hour later, gave additional orders and administered treatment to the resident's legs. During an interview on 05/12/26 at 3:20 P.M., the administrator said he/she would expect the nurse to educate the resident about the hot water he/she requested, and ensure the water was not above 120 degrees F when delivered to the resident for safety. 3. Review of the facility's Fall Prevention Program policy, dated 10/31/24, showed each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. Review of the facility's Safe Resident Handling Transfers Policy, dated 05/14/24, showed it is the policy of the facility to ensure residents are handled and transferred safely to prevent or minimize risk for injury and provide a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards of practice. 4. Review of Resident #2's Quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively intact, and required substantial/maximal assistance to roll left and right in bed. Review of the resident's care plan, dated 03/27/26, showed staff assessed the resident is able to assist with turning side to side in bed with use of side rails, is totally dependent on two staff for repositioning and turning in bed every two hours and as necessary, and is totally dependent on two or more staff for mechanical lift transfer. Review of the facility's investigation, dated 04/17/26, showed: -Certified Nursing Assistant (CNA) E documented in his/her written statement he/she went to roll the resident on his/her right side, the resident's legs came too far over to the side, he/she could not keep the resident on the bed and the resident slid off the bed;-Staff in-serviced on the facility's Fall Prevention and Safe Resident Handling policies;-CNA E counseled regarding a safety violation of attempting to roll a resident who required two staff to assist by him/herself. Review of the residents' progress notes, dated 04/17/26, showed staff documented: -The resident fell out of bed around 4:50 A.M., resident assessed, the Nurse Practitioner was contacted and gave orders to send resident to the emergency room for evaluation and treatment, resident left facility via EMS approximately 5:15 A.M.-The resident returned from hospital and assisted to bed with mechanical lift. During an interview on 05/12/26 at 1:32 P.M., the DON said he/she expects staff to follow the directions in the resident's care plan and electronic medical record to ensure safe and adequate care is provided to the resident. The DON said the resident was evaluated at the hospital and returned without injuries and without new orders. The DON said staff were educated on patient care assistance, transfer assist and fall prevention, and he/she individually counseled CNA E on proper assistance during cares. During an interview on 05/12/26 at 3:20 P.M., the administrator said he/she expects staff to follow the directions in the resident's care plan to provide safe and adequate care for the resident. He/She said CNA E should not have attempted to turn the resident by him/herself, and the nursing staff were re-educated on the facility's polices regarding care assist, transfer, and fall prevention, to ensure safety for all residents. Intake# 3007759Complaint #2994376