

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 04/25/2024
NAME OF PROVIDER OR SUPPLIER Rest Haven Convalescent and Retirement Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>42815</p> <p>Based on interviews and record review, facility staff failed to notify one resident's (Resident #26) representative in a timely manner after a report of potential abuse for one resident (Resident #1) out of twelve sampled residents. The facility census was 45.</p> <p>1. Review of the facility's policy titled, Abuse Reporting and Investigation, undated, showed if a suspected and/or witnessed account of abuse is reported, such as physical, emotional, sexual, or major injury of unknown origin any of these must be reported to the Administrator, as well as the Director of Nursing (DON), the residents representative, doctor, and the State Agency as immediately but no longer than two hours after suspected incident.</p> <p>2. Review of Resident #26's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 04/07/24, showed staff assessed the resident as:</p> <ul style="list-style-type: none"> -Severe cognitive impairment; -Diagnosis of high blood pressure, Alzheimer's (a progressive disease that destroys memory and other important mental functions), anxiety, and depression. <p>Review of the facility's Incident/Accident Report, dated 04/13/24, showed the report did not contain documentation staff contacted the resident's family member.</p> <p>During an interview on 04/19/24 at 12:10 P.M., Licensed Practical Nurse (LPN) A said staff are directed to notify resident's family after an allegation of abuse had been reported. He/She said the DON or administrator was responsible to contact the resident's family member. He/She said he/she did not know if the resident's family was contacted.</p> <p>During an interview on 04/19/24 at 12:35 P.M., the administrator said staff are educated to notify the resident's family after an allegation of abuse. He/She said the nurse should have notified the resident's family after the report of abuse.</p> <p>During an interview on 04/19/24 at 12:35 P.M., the DON said staff are educated to notify the resident's family after an allegation of abuse. He/She said the nurse should have notified the resident's family after the report of abuse. He/She checked and the nurse did not contact the family after the allegation.</p> <p>(continued on next page)</p>

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>MO002347670</p>

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>50422</p> <p>Based on interview and record review, facility staff failed to provide one resident (Resident # 32) out of one sampled resident with an appropriate follow-up plan/resolution in response to his/her grievances within 72 hours. The facility census was 45.</p> <p>1. Review of the facility's policy titled, Resident Concerns and Grievances Policy and Procedures, undated, showed staff were directed to:</p> <ul style="list-style-type: none"> -Responded to resident/family shall be made as soon as possible and preferably immediately. Actions taken to resolve the complaint shall be made within 72 hours from the time the Concern/Grievance Form was received; -Responded may be written or verbal, depending on the situation. A Resident/family concern/grievance form is available; -Section three of the form is to be completed by the employee designated to ensure satisfaction with the resolution of complaints; -The Administrator or designee will then complete Section four of the form by checking the appropriate box indicating resolution or further actions required. All concerns/grievances forms will be signed off by the Administrator; -Responses, appropriate plan/resolution to all complaints, and follow up with resident and/or family will be made within 72 hours; -The Administrator will sign off on all completed concerns/grievance forms, ensuring resident and/or family satisfaction. <p>Review of the resident's facility grievance form, dated 02/20/24, showed staff documented the resident reported his/her gaming console missing. Review showed the grievance form did not contain documentation staff followed up with resident and/or the residents family within 72 hours.</p> <p>During an interview on 04/23/24 at 11:36 A.M., Resident #32 said he/she had a gaming console in a box went missing about one month ago out of his/her room. He/She said he/she reported the missing gaming console to social services and there was no follow up on his/her grievance.</p> <p>During an interview on 04/25/24 at 12:58 P.M., License Practical Nurse (LPN) F said that when a resident reports something missing, he/she helps them look for the item, if unable to find the item he/she tells the Social Services Director and he/she files a grievance. He/She states that he/she lets the family know.</p> <p>(continued on next page)</p>

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/24/24 at 11:11 A.M., the Social Service Director said when a resident reports something missing, he/she reports it to administrator, writes up a grievance, and does an investigation. He/She said the facility will replace the item as close as possible. He/She said they will talk with the resident, let them know the result and make sure they agree with the replacement of the item.</p> <p>During an interview on 04/24/24 at 02:35 P.M., the Social Service Director said the resident did report the missing gaming console and he/she has the grievance form. He/She said there was talk about someone going to a pawn shop and buying one to replace it, but the investigation is not completed yet.</p> <p>During an interview on 04/25/24 at 01:43 P.M., the Director of Nursing said when a resident reports something missing, he/she will look for the item, if unable to find will report to Social Services Director to file a grievance. He/She said if the item can be replaced quickly then they will. He/she said if the item is difficult to find a replacement it may take longer to replace. He/She said the resident or resident representative should be notified within 30 days of the decision of the grievance.</p> <p>During an interview on 04/25/24 at 01:50 P.M., the administrator said the resident should be notified within five days and let the resident know they were unable to find the item. He/She states the facility will replace the item, or the resident or resident representative can go shopping for the item and bring the receipt. The facility will reimburse the resident the amount of the item.</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>39644</p> <p>Based on interviews and record review, facility staff failed to report an allegation of physical and verbal abuse to the Department of Health and Senior Services (DHSS) for one resident (Resident #26) within the two hour timeframe. The facility census was 45.</p> <p>1. Review of the facility's policy, Abuse Reporting and Investigation, undated, showed staff if a suspected and/or witnessed account of abuse is reported, such as physical, emotional, sexual, or major injury of unknown origin any of these must be reported to the administrator, as well as the Director of Nursing (DON), the residents representative, doctor, and the State Agency immediately but no longer than two hours after suspected incident.</p> <p>2. Review of Resident #26's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 04/07/24, showed staff assessed the resident with severe cognitive impairment.</p> <p>Review of the facility's investigation, dated 04/13/24, showed the facility documented a suspected physical and verbal incident between the resident and Certified Nurse Aide (CNA) M. The report did not contain documentation the facility contacted DHSS within the two hour timeframe after the allegation of suspected abuse.</p> <p>During an interview on 04/19/24 at 12:10 P.M., Licensed Practical Nurse (LPN) A said staff are directed to report allegations of abuse to the Director of Nursing (DON) and/or administrator. He/She said the DON or administrator would contact the appropriate parties.</p> <p>During an interview on 04/19/24 at 11:01 A.M., the DON said DHSS should be contacted within two hours after receiving a report of abuse. He/She said he/she did not contact DHSS because he/she did not believe the situation involved abuse.</p> <p>During an interview on 04/19/24 at 12:35 P.M., the administrator said DHSS should be contacted within two hours after receiving a report of abuse. He/She said he/she did not contact DHSS because he/she did not know the allegation included physical abuse.</p> <p>MO002347670</p>

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<p>F 0639</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Maintain 15 months of resident assessments in the resident's active clinical record.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43327</p> <p>Based on interview and record review facility staff failed to maintain fifteen (15) months of Minimum Data Set (MDS), a federally mandated resident assessment tool, assessments in the resident's active record for eight (Resident #1, #7, #13, #17, #23, #24, #26, and #32) of eight of sampled residents who were admitted greater than 15 months. The census was 54.</p> <p>1. Review of the facility's MDS completion and submission timeframes policy dated 2010, showed the policy did not contain direction for maintaining MDS assessments.</p> <p>Review of the Resident Assessment Instrument (RAI) manual, dated October 2023, showed that a nursing home must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review, and revise the resident's comprehensive plan of care.</p> <p>2. Review of #1's medical record showed:</p> <ul style="list-style-type: none"> -The resident admitted to the facility on [DATE]; -The record did not contain 15 months of MDS assessments. <p>3. Review of #7's medical record showed:</p> <ul style="list-style-type: none"> -The resident admitted to the facility on [DATE]; -The record did not contain 15 months of MDS assessments. <p>4. Review of 13's medical record showed:</p> <ul style="list-style-type: none"> -The resident admitted to the facility on [DATE]; -The record did not contain 15 months of MDS assessments. <p>5. Review of #17's medical record showed:</p> <ul style="list-style-type: none"> -The resident admitted to the facility on [DATE]; -The record did not contain 15 months of MDS assessments. <p>6. Review of #23's medical record showed:</p> <ul style="list-style-type: none"> -The resident admitted to the facility on [DATE]; -The record did not contain 15 months of MDS assessments. <p>7. Review of #24's medical record showed:</p> <p>(continued on next page)</p>

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<p>F 0639</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>-The resident admitted to the facility on [DATE];</p> <p>-The record did not contain 15 months of MDS assessments.</p> <p>8. Review of #26's medical record showed:</p> <p>-The resident admitted to the facility on [DATE];</p> <p>-The record did not contain 15 months of MDS assessments.</p> <p>9. Review of #32's medical record showed:</p> <p>-The resident admitted to the facility on [DATE];</p> <p>-The record did not contain 15 months of MDS assessments.</p> <p>10. During an interview on 04/23/24 at 10:56 A.M., the MDS nurse said the MDS assessments are not located with the residents active record. He/She said the assessments are in boxes in his/her office and the social workers office. He/She said when he/she is not in the facility, the assessments would not be available to other staff to review. He/She was not aware of the requirement.</p> <p>During an interview on 04/25/24 at 1:20 P.M., the Administrator said MDS information/assessments should be in the residents active record and readily accessible for at least seven years.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43327</p> <p>Based on record review and interview, facility staff failed to document an accurate Minimum Data Set (MDS) assessment (a federally mandated assessment instrument) when staff coded three (Resident #7, #23, and #40) of three sampled residents took an anticoagulant medication (medication used to thin the blood) when the residents were not prescribed an anticoagulant medication. The facility census was 45.</p> <p>1. Review of the facility's MDS completion and submission timeframes policy, dated 2010, did not contain direction for coding the MDS assessment.</p> <p>Review of the Resident Assessment Instrument (RAI) manual, dated October 2023, showed: Do not code antiplatelet medications such as aspirin/extended release or clopidogrel (antiplatelet) as an anticoagulant.</p> <p>2. Review of Resident #7's Quarterly MDS, dated [DATE], showed the MDS coded for use of an anticoagulant in the 7-day lookback period.</p> <p>Review of the resident's physician order sheet (POS), dated January 1 through January 31, 2024, showed the POS did not contain a physician order for an anticoagulant.</p> <p>3. Review of Resident #23's Quarterly MDS, dated [DATE], showed the MDS was coded for use of an anticoagulant in the 7-day lookback period.</p> <p>Review of the resident's POS, dated February 1 through February 29 and March 1 through March 31, 2024, showed the POS did not contain a physician order for an anticoagulant.</p> <p>4. Review of Resident #40's Quarterly MDS, dated [DATE], showed the MDS was coded for use of an anticoagulant in the 7-day lookback period.</p> <p>Review of the resident's POS, dated March 1 through March 31, 2024, showed the POS did not contain a physician order for an anticoagulant.</p> <p>5. During an interview on 04/25/24 at 12:01 P.M., the MDS nurse said he/she was coding Plavix (helps prevent blood clots) and Aspirin (pain and inflammation reducer) as anticoagulants because he/she did not know they were not supposed to be coded that way. He/She said he/she has an RAI manual but has not used it lately due to having so much other stuff to work on due to helping with resident care.</p> <p>During an interview on 4/25/24 at 1:20 P.M., the administrator said the MDS coordinator is responsible to code the MDS assessment and should use the RAI manual for correct coding. He/She said he/she thought Aspirin and Plavix were considered blood thinners and would have been coded an anticoagulant.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47193</p> <p>Based on interview and record review, facility staff failed to review and revise care plans after falls for four residents (#4, #24, #36 and #47) of twelve sampled residents. Staff failed to invite residents to their care conference for two residents (#32 and #35) of twelve sampled of residents. The facility census was 45.</p> <p>1. Review of the facility's policy titled, Care Plans, Comprehensive Person Centered, revised 10/2016, showed:</p> <ul style="list-style-type: none"> -A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident; -The care plan intervention is derived from a thorough analysis of the information gathered as part of the comprehensive assessment; -Comprehensive assessments, care planning and the care delivery process involve collecting and analyzing information, choosing and initiating interventions, and then monitoring results and adjusting interventions; -If a significant change in the resident's physical or mental condition occurs, a comprehensive assessment of the resident condition will be conducted as required by current Omnibus Budget Reconciliation Act (OBRA) regulations governing resident assessments. <p>2. Review of Resident #4's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 02/14/24, showed the following:</p> <ul style="list-style-type: none"> -Severe cognitive impairment; -Had two or more falls since last assessment; -Diagnosis of moderate intellectual disabilities. <p>Review of the resident's medical record showed the resident had a fall on the following dates:</p> <ul style="list-style-type: none"> -01/13/24; -01/17/24; -01/18/24; -02/04/24; -02/22/24. <p>(continued on next page)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the resident's care plan, dated 02/27/24, showed the plan did not contain documentation of the resident's falls or new fall interventions.</p> <p>3. Review of Resident #24's quarterly MDS dated [DATE], showed the following:</p> <ul style="list-style-type: none"> -Modified independence; -Independent with transfers; -Had had no falls since last assessment. <p>Review of the resident's medical record, showed the resident had a fall on the following dates:</p> <ul style="list-style-type: none"> -02/29/24; -03/19/24; -04/05/24. <p>Review of the resident's care plan, dated 02/06/24, showed the plan did not contain documentation of the residents falls or new fall interventions.</p> <p>4. Review of Resident #36's admission MDS), dated [DATE], showed the following:</p> <ul style="list-style-type: none"> -Moderate cognitive impairment; -Diagnosis of dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities). <p>Review of the resident's medical records, showed the resident had an unwitnessed fall on 03/25/24.</p> <p>Review of the resident's care plan, dated 04/09/24, showed staff documented the resident did not have a fall since being admitted to the facility and did not contain documentation of the resident's fall or new fall interventions.</p> <p>5. Review of Resident #47's admission MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> -Severe cognitive impairment; -Had two or more falls since last assessment; -Diagnosis of dementia. <p>Review of the resident's medical records showed the resident had a fall on the following dates:</p> <ul style="list-style-type: none"> -01/06/24; -01/27/24; <p>(continued on next page)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-01/29/24;</p> <p>-02/06/24;</p> <p>-02/20/24;</p> <p>-02/25/24;</p> <p>-02/26/24;</p> <p>-03/15/24;</p> <p>-03/19/24;</p> <p>-03/25/26;</p> <p>-03/29/26.</p> <p>Review of the resident's care plan, dated 03/26/24, showed the plan did not contain documentation of the resident's falls or new fall interventions.</p> <p>During an interview on 04/25/24 at 1:20 P.M., the Director of Nursing (DON) said it is his/her expectation the resident's care plan be updated with falls and interventions. He/She said the MDS coordinator is responsible for updating care plans. He/She is unsure why falls are not addressed on the care plan.</p> <p>During an interview on 04/25/24 at 1:43 P.M., the administrator said it is his/her expectation that falls are addressed on the resident's care plan. He/She said he/she expects them to be updated with new interventions. He/She said the MDS coordinator was responsible for updating and maintaining care plans. He/She is unsure why they were not updated.</p> <p>6. Review of the facility's policy titled, Care Planning-Interdisciplinary Team, revised 09/2013, showed:</p> <p>-The resident, the resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan;</p> <p>-Every effort will be made to schedule care plan meetins at the best time of the day for the resident and family.</p> <p>7. Review of Resident #32's Quarterly MDS, dated [DATE], showed the following:</p> <p>-Independent with all activities of daily living (ADL's);</p> <p>-Participation in assessment and goal setting-Resident.</p> <p>Review of the resident's care plan, dated 02/02/24, showed the following:</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-Resident did not have issues with communicating his/her needs and wants and is able to understand when spoken to;</p> <p>-Allow him/her choices in his/her care with things he/she is able to make simple decisions with.</p> <p>During interview on 04/23/24 at 11:38 A.M., the resident said he/she does not get invited to care plan meetings. He/She said that he/she did not even know that care plan meetings were a thing.</p> <p>8. Review of Resident #35's Quarterly MDS, dated [DATE], showed the following:</p> <p>-Independent with all ADL's;</p> <p>-Participation in assessment and goal setting-Resident.</p> <p>Review of the resident's care plan, dated 02/23/24, showed allow resident choices in his/her care whenever possible.</p> <p>During interview on 04/23/24 at 8:36 A.M., the resident said he/she is not sure about his/her care plan meetings and said that he/she has never been invited to one.</p> <p>During interview on 04/24/24 at 2:51 P.M., the MDS Coordinator said he/she has not been keeping up with the forms for when care plan meetings happen and who attended the care plan meeting. He/She said the last forms completed were from 2022-2023, but none since then. He/She said care plan meetings are about every three months or with a sufficient change. He/She said residents, family members, or anyone that is over resident care is invited to attend care plan meetings.</p> <p>During interview on 04/25/24 at 1:43 P.M., the Director of Nursing said care plans are done on admission, quarterly, and any changes. He/She said residents and family are invited. He/She said they go to residents and ask if they want to come to their meeting. He/She said he/she does not know if it is recorded on who attends that care plan meetings. He/She said interventions are to be updated quartely and if an intervention is not working. He/She said he/she expects falls with new interventions to be on care plans.</p> <p>During interview on 04/25/24 at 1:50 P.M., the administrator said care plans are expected to be done on admission and quartely. The administrator said he/she would expect care plans to be updated with any changes.</p> <p>MO002348121</p> <p>50422</p>

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 04/25/2024
NAME OF PROVIDER OR SUPPLIER Rest Haven Convalescent and Retirement Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1800 South Ingram Sedalia, MO 65301	

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>39644</p> <p>Based on interview and record review, facility staff failed to provide the services of a Registered Nurse (RN), for at least eight consecutive hours per day, seven days a week. The facility census was 45.</p> <ol style="list-style-type: none"> Review of the facility's policies showed the facility did not provide a policy for RN coverage. Review of the facility's RN staff schedule, dated October 2023, showed the facility did not have an RN in the building for the dates of: <ul style="list-style-type: none"> -Sunday 10/01/23; -Saturday 10/14/23; -Sunday 10/15/23; -Saturday 10/28/23; -Sunday 10/29/23. Review of the facility's RN staff schedule, dated November 2023, showed the facility did not have an RN in the building for the dates of: <ul style="list-style-type: none"> -Saturday 11/04/23; -Sunday 11/05/23; -Saturday 11/25/23; -Sunday 11/26/23. Review of the facility's RN staff schedule, dated December 2023, showed the facility did not have an RN in the building for the dates of: <ul style="list-style-type: none"> -Saturday 12/09/23; -Sunday 12/10/23; -Saturday 12/23/23; -Sunday 12/24/23. Review of the facility's RN staff schedule, dated January 2024 showed the facility did not have an RN in the building for the dates of: <p>(continued on next page)</p>

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-Saturday 01/06/24;</p> <p>-Sunday 01/07/24;</p> <p>-Saturday 01/20/24;</p> <p>-Sunday 01/21/24.</p> <p>6. Review of the facility's RN staff schedule, dated February 2024 showed the facility did not have an RN in the building on Saturday 02/03/24 and Sunday 02/25/24.</p> <p>7. Review of the facility's RN staff schedule, dated March 2024, showed the facility did not have an RN in the building for the dates of:</p> <p>-Saturday 03/02/24;</p> <p>-Saturday 03/16/24;</p> <p>-Sunday 03/17/24;</p> <p>-Saturday 03/30/24;</p> <p>-Sunday 03/31/24.</p> <p>8. Review of the facility's RN staff schedule, dated April 2024, showed the facility did not have an RN in the building for the dates of:</p> <p>-Saturday 04/13/24;</p> <p>-Sunday 04/14/24;</p> <p>-Saturday 04/21/24;</p> <p>-Saturday 04/27/24;</p> <p>-Sunday 04/28/24.</p> <p>9. During an interview on 04/25/24 at 1:25 P.M., the Director of Nursing (DON) said We just don't have any Registered Nurse's, there is just myself and one other RN on staff. The DON said he/she works Monday through Friday anywhere from 8-10 hours. The DON said all he/she can do is let the administrator know if there isn't RN coverage, and see if they can get some agency help, however that doesn't always work out.</p> <p>During an interview on 04/25/24 at 1:25 P.M., the administrator said if there is no RN coverage for a certain day she will call her boss, and get approval to contact agency staff. The Administrator said she does contact the agency, but they don't always provide anyone to cover.</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>39644</p> <p>Based on observation, interview, and record review, facility staff failed to complete or post required nurse staffing information in an area readily accessible to residents and visitors. The facility census was 45.</p> <p>1. Review of the facility's policy titled, Posting Direct Care Daily Staffing Numbers, revised 7/2016, showed within two hours of the beginning of each shift, the number of Licensed Nurses (Registered nurses, Licensed practical nurses, and Licensed vocational nurses) and the number of unlicensed nursing personnel (certified nurse aides) directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format.</p> <p>Observation on 4/22/25 3:32 P.M., showed facility staff did not display the nurse staff posting sheet in an area readily accessible to residents and visitors.</p> <p>Observation on 4/23/25 9:32 A.M., showed facility staff did not display the nurse staff posting sheet in an area readily accessible to residents and visitors.</p> <p>Observation on 4/24/25 1:55 P.M., showed facility staff did not display the nurse staff posting sheet in an area readily accessible to residents and visitors.</p> <p>Observation on 4/25/25 12:52 P.M., showed facility staff did not display the nurse staff posting sheet in an area readily accessible to residents and visitors.</p> <p>During an interview on 04/25/24 at 1:26 P.M., the Director of Nursing (DON) said he/she is responsible for the posted nurse staff schedule. The DON said he/she was not aware it needed to be posted in a certain location and prominently place so its visible to residents and visitors.</p> <p>During an interview on 04/25/24 at 1:26 P.M., the administrator said, I was told in the past it was okay to post where it's at in the back dining room, so that is where its been every since. The administrator confirmed the back dining room is rarely used and the outside door is not open to the public.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>50422</p> <p>Based on observation, interview, and record review, facility staff failed to ensure multi-dose medications contained an open date and/or resident name, dispose of expired medications, and failed to store only medications in the medication storage reffridgerator. The facility census was 45.</p> <p>1. Review of the facility's Storage of Medication policy, revised 04/2007, showed facility staff were directed as follows:</p> <ul style="list-style-type: none"> -Drugs and biologicals shall be stored in the packaging, containers or other dispensing systems in which they are received; -Drug containers which have missing, incomplete, improper, or incorrect labels shall be returned to the pharmacy for proper labeling before storing; -The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed; -Drugs shall be stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications shall be assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medication of several residents; -Medications requiring refrigeration must be stored in a refrigerator located in the drug room at the nurses' station or other secured location. Medications must be stored separately from food and must be labeled accordingly. <p>2. Observation on 04/22/24 at 9:57 A.M., showed the 200 hall medication cart contained:</p> <ul style="list-style-type: none"> -Three open bottle of prescription fluticasone propionate nasal spray (used for allergies) undated with illegible resident name; -One lubricant eye drops (used for dry eye and allergies) undated and illegible resident name; -An opened bottle of timolol mal sol 0.5% (used for glaucoma) undated; -An opened bottle of rhopressa sol 0.02% (used for glaucoma) undated; -An opened bottle of systane complete sol 0.6% (used for dry eye) undated; -An opened bottle of polyethylene glycol (used for constipation) undated. <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 04/22/24 at 09:50 A.M., Certified Medication Technician (CMT) G said staff should reorder the medication if unable to read label. He/She said if medication is used a lot the names sometimes wear off. He/She said they normally try to keep the bottles in the bag they came in but was in a hurry and trying to train a new CMT. He/She said if medication is not labeled then they can't be sure what is in the bottle. He/She said it falls on all of us to make sure all medications are checked for expired medications. He/She said if you give expired medications the resident may not work to its full potential. He/She said the pharmacy does quarterly med room reviews.</p> <p>3. Observation on 04/22/24 at 10:25 A.M., showed the 200 hall Nurse medication storage cart contained:</p> <ul style="list-style-type: none"> -An opened bottle of atropine sulfate eye drops (used to dilate pupils) undated and unlabeled; -An opened vial of lidocaine 1% (used for local anesthetic) undated and unlabeled. <p>During an interview on 04/22/24 at 10:20 A.M., License Practical Nurse (LPN) A said the atropine was used for a resident who is no longer at this facility. He/She said the lidocaine should have been destroyed after the resident stopped taking the medication.</p> <p>4. Observation on 04/22/24 at 10:15 A.M., showed the 200 hall medication room contained:</p> <ul style="list-style-type: none"> -An open bottle of multi-probiotic (used to boost immunity against infections) with an expiration date of 01/22; -Two opened bottles of Imodium ad (used for diarrhea) with an expiration date of 01/24; -An unopened bottle for ferrous sulfate (used to treat iron deficiency) with an expiration date of 08/23. <p>During an interview on 04/22/24 at 10:20 A.M., LPN A said the nurses are responsible to pull expired medications, if not right away, then should be pulled out and destroyed. He/She said nurses should check medications at least weekly.</p> <p>During an interview on 04/25/24 at 01:43 P.M., the Director of Nursing (DON) said it is the medication technician and charge nurses responsibility to check for expired medications. He/She said he/she hoped that medications are checked on a daily basis, but realistically a weekly basis. He/She said expired medications are not usable.</p> <p>During an interview on 04/25/24 at 01:50 P.M., the administrator said it is the med tech and charge nurses' responsibility to check for expired medications.</p> <p>5. Observation on 04/22/24 at 10:15 A.M., showed the medication refrigerator in the 200 hall medication room contained the following:</p> <ul style="list-style-type: none"> -A zip lock bag of chocolate candy undated; -A packaged uncrustable sandwich undated; <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-A packaged cinnamon roll undated;</p> <p>-An opened plastic cup with a brown frozen drink.</p> <p>During an interview on 04/22/24 at 09:50 A.M., CMT G said food should not be in the refrigerators with medications.</p> <p>During an interview on 04/25/24 at 12:58 P.M., LPN F said food and drink should not be in the medication reffridgerator because of contamination.</p> <p>During an interview on 04/25/24 at 01:43 P.M., the DON said food and drink should not be stored in the medication fridge due to contamination. He/She said the charge nurse is responsible to make sure no food or drink is in the medication fridge since they are in the fridge daily to count narcotics.</p> <p>During an interview on 04/25/24 at 01:50 P.M., the administrator said food and drink should not be stored in the medication fridge. He/She said the charge nurse is responsible to make sure no food or drink is in the medication fridge.</p>

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>45564</p> <p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>Based on observation, interview and record review, facility staff failed to serve food in accordance with the nutritionally calculated menus and standardized recipes when facility staff failed to provide the correct portion sizes to three residents (Residents #4, #31, and #44) of three residents sampled who received pureed food items. The census was 45.</p> <p>1. Review of the facility's policies, showed the policies did not contain instructions for staff to prepare multiple portions of pureed food items.</p> <p>Review of the standardized menu for Week Four, Day Three showed residents receiving pureed food items were to receive one # 10 (3.2 ounces) scoop of beef stroganoff, one #8 (four ounces) scoop of egg noodles, one #10 scoop of green beans, one #10 scoop of sweet dinner roll, one #16 (two ounces) scoop of gooey butter bar and a beverage.</p> <p>Observation on 04/23/24 at 11:45 A.M., showed Cook L added two (4 oz) scoops of egg noodles, three (3 oz) scoops of beef stroganoff and beef broth to a food processor and pureed the items. The pureed items were placed in a pan and added to the serving line.</p> <p>Observation on 04/23/24 at 12:39 P.M., showed Cook L served Residents #31 and #44 who received pureed diets, one four ounce scoop of pureed beef stroganoff and noodles, one four ounce scoop of beans. Observation showed the residents did not receive 3.2 ounces of beef stroganoff and four ounces of egg noodles. Observation showed the residents received four ounces of beans instead of 3.2 ounces in accordance with the menu.</p> <p>2. Review of Resident #4's physician order sheet (POS), dated 03/25/24, showed the resident was to receive mechanical soft foods with pureed meats. The POS also showed the resident was to receive double portions or shakes with meals three times daily.</p> <p>Observation on 04/23/24 at 12:41 P.M., showed Cook L served Resident #4, four ounces of pureed beef stroganoff and noodles over four ounces of egg noodles. Observation showed the resident did not receive 3.2 ounces of beef stroganoff and four ounces of egg noodles.</p> <p>During an interview on 04/23/24 at 1:55 P.M., Cook L said another cook told him/her the new menus did not have puree recipes. Cook L said he/she combined three servings of beef stroganoff with two servings of noodles because one resident only received pureed meats. Cook L said the resident who was to receive only pureed meat received pureed meat and noodles served over noodles. Cook L said the residents who received pureed meals did not receive the correct serving size. Cook L said he/she served the residents based on the beef stroganoff serving size and did not think about the noodles.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/24/24 at 9:53 A.M., the Dietary Supervisor (DS) said the facility changed food vendors and went to new menus in December of 2023. The DS said staff were supposed to know where puree recipes were kept. The DS said the pureed recipes were kept in his/her office and it was his/her responsibility to ensure staff knew where the recipes were kept. The DS said staff should have provided meat and noodle portions for pureed residents even though the items were combined. The DS staff should not have served pureed meat and noodles on top of noodles.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>39644</p> <p>Based on observation, interview and record review, facility staff failed to keep residents medical record accessible and systematically organized in accordance with accepted professional standards for 23 residents (Resident #1, #4, #7, #9, #13, #14, #17, #21, #23, #24, #26, #28, #31, #32, #35, #36, #37, #40, #41, #44, #47, #48, and #351) out of 23 sampled residents. The facility census was 45.</p> <p>1. Review of sampled Resident #1, #4, #7, #9, #13, #14, #17, #21, #23, #24, #26, #28, #31, #32, #35, #36, #37, #40, #41, #44, #47, #48, and #351 medical records showed the medical records for the following areas not accessible for:</p> <ul style="list-style-type: none"> -Falls; -Skin assessments; -Wound documentation; -Labs; -Gradual Dose Reductions (GDR); -Pharmacy Recommendations; -Immunization Records. <p>During an interview on 04/25/24 at 1:27 P.M., the Director of Nursing (DON) said his/her expectation with falls is they be documented and to include what happened, how it happened, assessments done, interventions and who was contacted. The DON said the facility does not currently have a system in place for this process. The DON said GDR and Pharmacy Recommendations should also be on resident chart and filed together, so they are easily accessible. His/Her expectation is skin assessments and any labs performed on a resident should also be in the resident's chart, so they are easily accessible. The DON said only he/she and one other staff member have access to get into the lab portal to print or see lab results. he/She said this could be part of the issue, and also no one wants to file so it just does not get done, however the expectation is they are put in the chart. The DON said, I expect all this information to be in the resident's medical record, but I know it's not.</p> <p>During an interview on 04/25/24 at 1:29 P.M., the administrator said her expectation is that all the resident care information should be in the residents chart, and accessible to staff.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47193</p> <p>Based on observation, interview, and record review, facility staff failed to perform appropriate hand hygiene and glove changes during incontinence care for one (Resident #14) out of one sampled resident. Facility staff failed to perform appropriate hand hygiene and glove changes during catheter care for two (Resident #4 and #36) out of two sampled residents. Facility staff failed to perform appropriate hand hygiene and glove changes during wound care for one (Resident #44) out of two sampled residents. The facility census was 45.</p> <p>1. Review of the facility's policy titled, Standard Precautions, undated, showed staff are directed to:</p> <ul style="list-style-type: none"> -Wash hands after touching blood, body fluids, secretions, excretions, and contaminated items, whether or not gloves are worn; -Wash hands immediately after gloves are removed, between resident contacts, and when otherwise indicated to avoid transfer of microorganisms to other residents or environments; -Wear gloves when touching blood, bodily fluids, secretions, excretions, and contaminated items; -Remove gloves promptly after use, before touching noncontaminated items and environmental surfaces, and before going to another resident, and washing hands immediately to avoid transfer of microorganisms to other residents or environments. <p>Review of the facility's policy titled, Perineal Care, revised 10/2010, showed staff are directed to:</p> <ul style="list-style-type: none"> -Wash and dry hands thoroughly; -Put on gloves; -Discard disposable items into designated containers; -Remove gloves and discard into designated container. Wash and dry hands thoroughly; -Wash and dry hands thoroughly. <p>2. Review of Resident #14's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 04/02/24, showed the following:</p> <ul style="list-style-type: none"> -Limited Range of motion impairment on one side; -Partial/moderate assistance with toileting, upper and lower body dressing, and personal hygiene; -Dependent assistance with toilet transfer; <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Occasionally incontinent with bladder and bowel;</p> <p>-At risk for developing pressure ulcers.</p> <p>Observation on 04/22/24 at 2:30 P.M., nurse aide (NA) H and NA I entered the resident's room to perform perineal care. NA H and NA I did not perform hand hygiene before they applied gloves and assisted resident to bed. Observation showed NA I cleaned resident's bowel movement and with the same soiled gloves did place a clean brief under the resident. NA I removed his/her gloves and did not perform hand hygiene before he/she applied new gloves and touched the resident. NA H did not change gloves, or perform hand hygiene before he/she performed frontal peri care, applied powder, latched the brief and assisted the resident with his/her clothing.</p> <p>Observation on 04/23/24 at 08:57 A.M., showed NA I and Certified Medication Tech (CMT) J entered the resident's room to perform peri care. CMT J and NA I did not perform hand hygiene before they applied gloves. NA I and CMT J assisted resident to bed. CMT J cleaned resident's bowel from his/her buttock and placed the soiled brief in trash can. CMT J removed his/her gloves and did not perform hand hygiene before he/she applied new gloves. NA I applied a new brief under resident, rolled resident onto his/her back and applied the resident's brief. NA I and CMT J performed perineal care to resident in between legs or frontal peri area. NA I removed his/her gloves and did not perform hand hygiene before he/she assisted CMT J put on the resident's pants.</p> <p>During an interview on 05/01/24 at 09:35 A.M., NA I said staff should always wear gloves, wash hands or sanitize before applying gloves and after removing gloves. He/She said staff should change gloves after cleaning resident and sanitize hands before applying new gloves. He/She said hand hygiene education is provided upon hiring. He/She said he/she was in a hurry and forgot to change his/her gloves and sanitize in between when gloves were soiled after cleaning resident.</p> <p>During an interview on 04/25/24 at 12:54 P.M., License Practical Nurse (LPN) F said he/she expects the aides to wash hands for 20 seconds, dry hands with paper towel, use new paper towel to shut off water, then put gloves on. He/She said aides should wash hands or sanitize in between soiled cares and after removing gloves.</p> <p>During an interview on 04/25/24 at 01:43 P.M., the Director of Nursing (DON) said he/she expects staff to wash their hands when entering a resident's room, apply gloves, perform cares, take gloves off, wash hands again. He/She said he/she expects aides to remove soiled gloves during cares, sanitize, then apply new gloves to continue care.</p> <p>During an interview on 04/25/24 at 1:50 P.M., the administrator said she expects staff to follow hand hygiene policy when performing cares.</p> <p>3. Review of the facility's policy titled, Catheter Care, Urinary, revised 9/2014, showed staff are directed to:</p> <p>-Urinary drainage tubing must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder;</p> <p>-Use standard precautions when handling or manipulating the drainage system;</p> <p>(continued on next page)</p>		

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 04/25/2024
NAME OF PROVIDER OR SUPPLIER Rest Haven Convalescent and Retirement Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Maintain clean technique when handling or manipulating the catheter, or drainage bag;</p> <p>--Be sure the catheter tubing and drainage bag are kept off the floor;</p> <p>-Wash and dry hands thoroughly;</p> <p>-Put on gloves;</p> <p>-Wash the residents genitalia and perineum thoroughly with soap and water. Rinse the area well and towel dry;</p> <p>-Remove gloves and discard into the designated container. Wash and dry your hands thoroughly;</p> <p>-Remove gloves and discard into designated container. Wash and dry hands thoroughly;</p> <p>-Reposition the bed covers. Make the resident comfortable.</p> <p>4. Review of Resident #4's annual MDS, dated [DATE], showed the following:</p> <p>-Severe cognitive impairment;</p> <p>-Has an indwelling catheter.</p> <p>Observation on 04/24/24 at 8:30 A.M., showed Certified nurse aide (CNA) D and NA E entered the resident's room to provide catheter care. Observation showed the resident's catheter bag on the floor. CNA D cleaned the resident's bowel movement, did not change his/her gloves before he/she placed a clean brief under the resident, assisted the resident to his/her back, picked the catheter bag up off the floor, replaced the catheter bag with a leg bag, dressed the resident, covered the resident up, and moved wheel chair and adjusted the bed.</p> <p>5. Review of Resident #36's admission MDS, dated [DATE], showed the following:</p> <p>-Moderate cognitive impairment;</p> <p>-Has an indwelling catheter;</p> <p>-Urinary tract infection.</p> <p>Observation on 04/24/24 at 8:15 A.M., showed CNA D and NA E entered the resident's room to provide catheter care. NA E held the catheter bag up above the resident's waist and then CNA D took the bag and placed it on the bed on top of the resident's blanket. CNA D performed catheter care and did not change his/her gloves before he/she moved the catheter bag and replaced it with a leg bag, applied the residents brief, pulled up the resident's pants, helped the resident up to his/her bedside and moved the residents walker closer.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Rest Haven Convalescent and Retirement Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1800 South Ingram Sedalia, MO 65301	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/24/24 at 1:50 PM CNA D said staff should wash their hands when they walk into a resident's room, whenever they touch surfaces in a resident's room, when they are going from a clean task to a dirty task, whenever they change parts of the body during care, after all care and when they leave the residents room. CNA D said gloves should be worn during care and hands should be sanitized or wash any time the gloves are removed. He/She said glove changes should occur between clean and dirty tasks and whenever you change from one part of the body to another. He/She said catheters should never touch the floor in order to prevent cross contamination. He/She said he/she is not sure if there is a rule on how high up the bag is allowed to go. He/She said he/she forgot to change his/her gloves because he/she was nervous and running late. He/She said he/she was training NA E and running late for getting residents up for breakfast.</p> <p>During an interview on 04/30/24 at 1:27 P.M., the LPN A said catheter bags should never be placed on the floor or on top of the residents bed. He/She said catheters should always be located below the residents waist and hanging above the floor without touching.</p> <p>6. During an interview on 04/25/24 at 1:20 P.M., the DON said it is his/her expectation that his/her staff would perform hand hygiene when they entered the resident's room and then apply gloves and perform perineal care. He/She said after performing perineal care he/she would expect staff to remove gloves, perform hand hygiene, apply clean gloves, and then perform the resident's catheter care. He/She said after catheter care, he/she would expect staff to remove gloves, perform hand hygiene, apply clean gloves, and then disconnect and change the catheter bag. He/She said after changing out the catheter bags, he/she would expect staff to remove gloves and perform hand hygiene. He/She said he/she is not sure why staff would not be changing gloves or performing hand hygiene.</p> <p>During an interview on 04/25/24 at 1:43 P.M., the administrator said she expect his/her staff to perform hand hygiene before and after providing care. She said she expects staff to remove gloves, perform hand hygiene, and apply clean gloves between clean and dirty tasks when providing catheter care and changing catheter bags.</p> <p>7. Review of the facility's policy titled, Pressure Ulcer Treatment, revised 9/2013, showed staff are directed to:</p> <ul style="list-style-type: none"> -Wash and dry hands thoroughly; -Put on clean gloves. Loosen tape and remove soiled dressing; -Pull glove over dressing and discard into plastic or biohazard bag; -Wash and dry hands thoroughly; -Using clean technique, open other products (i.e., prescribed dressing; dry, clean gauze); -Wash and dry your hands thoroughly; -Put on clean gloves; -Clean the wound with ordered cleanser; <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Apply the ordered dressing;</p> <p>-Remove disposable gloves and discard into designated container. Wash and dry hands thoroughly.</p> <p>8. Review of Resident #44's admission MDS, dated [DATE], showed the following:</p> <p>-Severe cognitive impairment;</p> <p>-Required maximal assistance with toileting hygiene;</p> <p>-Diagnosis of cancer.</p> <p>Observation on 04/23/24 at 11:33 A.M., showed LPN A and NA B entered the resident's room to provide wound care. LPN A assisted the resident to his/her left side, removed his/her gloves and did not perform hand hygiene before he/she applied new gloves to prepare and pass supplies needed to clean and measure the residents wound. LPN A removed his/her gloves, removed a pen from his/her pocket and documented the residents wound size. LPN A did not perform hand hygiene before he/she applied new gloves to prepare the gauze with normal saline and cut the calcium alginate for the resident's wound dressing.</p> <p>During an interview on 04/25/24 at 1:20 P.M., the DON said it is his/her expectation that the nursing staff wash their hands after entering the resident's room and before leaving. When performing wound care he/she expects staff to remove gloves, perform hand hygiene and apply clean gloves after removing the resident's dressing and after they complete wound cleaning. It is his/her expectation that staff should remove their gloves and wash their hands after applying the wound dressing. He/She said he/she is not sure why the nursing staff would not be changing gloves and performing hand hygiene per their policy.</p> <p>During an interview on 04/25/24 at 1:43 P.M., the administrator said any time a nurse goes from a clean to dirty area they should be changing their gloves and performing hand hygiene.</p> <p>During an interview on 04/30/24 at 1:27 P.M., the LPN A said it is his/her expectation staff wash their hands and put on gloves before providing wound care and in between clean and dirty tasks. He/She said not changing gloves puts the resident at risk for cross contamination and infection. He/She was not sure why he/she did not perform hand hygiene after glove changes.</p> <p>50422</p>