

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  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Rest Haven Health Care Center		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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40424</b></p> <p>Based on observation, interview and record review, facility staff failed to provide a comfortable, safe, and homelike environment for residents, when staff failed to maintain walls, floors, bathrooms, and the building structure of resident occupied rooms and common areas. The facility census was 52.</p> <p>1. Review of the facility's Safe and Homelike Environment policy, dated 06/0524 showed:</p> <ul style="list-style-type: none"> <li>- In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This includes ensuring the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk;</li> <li>- The facility will create and maintain, to the extent possible, a homelike environment that demphasizes the institutional character of the setting;</li> <li>- Housekeeping and maintenance services will provide as necessary to maintain a sanitary and comfortable environment.</li> </ul> <p>2. Observation on 03/03/25 at 10:00 A.M., showed resident occupied room [ROOM NUMBER]'s door frame of the bathroom rusted and coming apart. The bathroom floor tile around the toilet stained.</p> <p>Observation on 03/03/25 at 10:12 A.M., showed resident occupied room [ROOM NUMBER]'s bathroom floor tile cracked, discolored and lifted away from the floor.</p> <p>Observation on 03/03/25 at 10:15 A.M., showed resident occupied room [ROOM NUMBER]'s floor separated with black stains in the cracks. The room had a heavy urine odor.</p> <p>Observation on 03/03/25 at 10:22 A.M., showed resident occupied room [ROOM NUMBER]'s floor cracked and separated with raised black stain in the cracks.</p> <p>Observation on 03/03/25 at 10:38 A.M., showed resident occupied room [ROOM NUMBER]'s bathroom floor sticky and the grab bar with a brown substance.</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
---	-------	-----------

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  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Rest Haven Health Care Center		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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 03/03/25 at 10:52 A.M., showed resident occupied room [ROOM NUMBER]'s bathroom floor with multiple stains around the toilet and the grab bar with a brown substance.</p> <p>3. During an interview on 03/06/25 at 7:29 A.M., the Director of Nursing (DON) said the Maintenance Director is responsible for repairs in the building. He/She said they were not sure how the repairs needed were reported to the Maintenance department.</p> <p>During an interview on 03/06/25 at 9:12 A.M, Certified Nurse Assistant (CNA) K said he/she tells maintenance directly when he/she notices a repair needed.</p> <p>During an interview on 03/06/25 at 9:23 A.M., Licensed Practical Nurse (LPN) A said staff tell maintenance if broken items are found. There is a paper repair log that can be filled out.</p> <p>During an interview on 03/06/25 at 1:06 P.M., the administrator said the Maintenance Director is responsible for repairs. He/She said administration is aware of many of the repairs needed and is overall responsible for ensuring they are completed.</p> <p>4. Observation on 03/05/25 during the Life Safety Code tour showed:</p> <ul style="list-style-type: none"> <li>-The light fixture in the bathroom between resident rooms [ROOM NUMBERS] contained rust;</li> <li>-The sink faucet in the bathroom between resident rooms [ROOM NUMBERS] corroded;</li> <li>-The sink in the bathroom between resident rooms [ROOM NUMBERS] contained an accumulation of a brown, rust appearing substance;</li> <li>-The shower room next to resident room [ROOM NUMBER]with a piece of plywood leaned against the wall. The water line behind the plywood had an active water leak;</li> <li>-A large section of fascia and gutters outside of resident rooms [ROOM NUMBERS] missing;</li> <li>-The roof drip edge outside room [ROOM NUMBER] loose with exposed roof decking.</li> </ul> <p>During an interview on 03/06/25 at 12:05 P.M., the maintenance director said he/she was responsible for building maintenance. The maintenance director said he/she never noticed the rusted light fixture or the brown sink. The maintenance director said he/she replaced light fixtures when he/she noticed they were damaged. The maintenance director said he/she found the water leak last week but he/she was not sure what was going on with it. The maintenance director said he/she had discussed the gaps in the floor with his/her regional maintenance director in the past month or so but there was no current plan to address the gaps. The maintenance director said the fascia and gutters were damaged during the last storm, which was in the past month. The maintenance director said he/she was not aware of the falling drip edge above room [ROOM NUMBER]. The maintenance director said the administrator was supposed to contact corporate staff to have the fascia and gutters repaired.</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  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Rest Haven Health Care Center		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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 03/06/25 at 2:15 P.M., the administrator said the maintenance director was responsible for interior and exterior building maintenance. The administrator said he/she did not know if the maintenance director had contacted anyone to repair the fascia and gutters in the resident courtyard. The administrator said he/she just started as interim administrator and was not aware of pending repairs.</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  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Rest Haven Health Care Center		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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43327</p> <p>Based on observation, interview and record review, facility staff failed to develop a comprehensive person-centered care plan to meet the resident's medical, nursing, mental and psychosocial needs for eight residents (Resident #1, #2, #9, #12, #18, #25, #45 and #258) out of 12 sampled residents. The facility's census was 52.</p> <p>1. Review of the Facility's Comprehensive Care Plans policy, dated 10/31/24, showed:</p> <p>-It is the policy of this facility to develop and implement a comprehensive person-centered care plan or each resident, consistent with resident rights, that include measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment;</p> <p>-Resident specific interventions that reflect the resident's needs and preferences.</p> <p>2. Review of Resident #1's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool completed by facility staff used to assess the care needs of the resident, dated 1/31/25, showed staff assessed the resident as follows:</p> <p>-Severe cognitive impairment;</p> <p>-Shortness of breath or trouble breathing when lying flat;</p> <p>-Received oxygen therapy;</p> <p>-Diagnosis of heart failure and profound intellectual disability (severe disability that limits a person ability to learn, develop, and communicate).</p> <p>Review of the physician order sheet (POS), dated 11/15/24, showed the record contained an order for two liters of oxygen via nasal canula as needed for shortness of breath.</p> <p>Review of the resident's care plan, dated 08/05/24, showed the care plan did not contain direction for respiratory therapy.</p> <p>Observation on 03/03/25 at 11:23 A.M., showed the resident with two liters of oxygen on via nasal canula.</p> <p>Observation on 03/04/25 at 11:07 A.M., showed the resident with two liters of oxygen on via nasal canula.</p> <p>Observation on 03/05/25 at 9:06 A.M., showed the resident with two liters of oxygen on via nasal canula.</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  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Rest Haven Health Care Center		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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 03/06/25 at 12:44 P.M., showed the resident with two liters of oxygen on via nasal canula.</p> <p>3. Review of Resident #2's Quarterly MDS, dated [DATE], showed staff assessed the resident as:</p> <ul style="list-style-type: none"> <li>-Cognitively intact;</li> <li>-On a pain management schedule;</li> <li>-Takes pain medication as needed;</li> <li>-No non-pharmacological interventions for pain;</li> <li>-No pain interview;</li> <li>-Presence of one unhealed Stage III pressure injury;</li> <li>-Presence of a diabetic foot ulcer.</li> </ul> <p>Review of the resident's POS, dated March 2025, showed an physician order on 01/27/25:</p> <ul style="list-style-type: none"> <li>-A pain assessment to be completed each shift;</li> <li>-Cleanse with wound cleanser, apply petroleum gauze followed by border gauze to both heel wounds and toe daily;</li> <li>-Wound cleanser and petroleum gauze, non-adhesive dressing and kerlix to third left toe daily.</li> </ul> <p>Review of the resident's POS, dated March 2025, showed a physician order on 09/18/24 for the resident to be a Full Code.</p> <p>Review of the residents face sheet, showed the resident had a Legal Guardian.</p> <p>Review of the resident's care plan, dated 02/26/25, showed the care plan did not contain direction, guidance or preferences for advanced directives, pain management, or skin/wound prevention.</p> <p>During an interview on 03/04/25 at 8:11 A.M., the resident said he/she has skin issues on his/her foot the facility does a treatment on and has pain daily related to cancer but is manageable with medication and rest.</p> <p>4. Review of Resident #9's Quarterly MDS, dated [DATE], showed staff assessed the resident as:</p> <ul style="list-style-type: none"> <li>-Cognitively intact;</li> <li>-Required partial to moderate assistance for toilet hygiene;</li> <li>-Required substantial to maximum assistance for toilet transfer;</li> </ul> <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  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Rest Haven Health Care Center		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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Diagnosis of stroke and moderately impaired vision.</p> <p>Review of the resident's care plan, dated 10/14/24, showed the resident is able to toilet independently but needs supervision or touch assist for safety.</p> <p>Observation on 03/03/25 at 2:33 P.M., showed two staff transfered the resident from the toilet to his/her wheelchair and provided toilet hygiene.</p> <p>During an interview on 03/03/25 at 2:33 P.M., the resident said staff are supposed to stay with him/her when he/she is on the toilet because he/she is blind. He/She said he/she gets scared and unsteady when being transferred and needs staff assistance.</p> <p>5. Review of Resident #12's Annual MDS dated [DATE], showed staff assessed the resident as:</p> <p>-Cognitively intact;</p> <p>-Required substantial to maximum assistance for showers;</p> <p>Review of the resident's care plan, dated 10/21/24, showed the care plan did not contain direction, guidance or preferences for showers.</p> <p>6. Review of Resident #18's Quarterly MDS, dated [DATE] showed staff assessed the resident as:</p> <p>-Cognitively intact;</p> <p>-On hospice, oxygen and presence of an indwelling catheter;</p> <p>-Diagnosis of heart failure.</p> <p>Review of the resident's care plan, dated 12/16/24, showed the care plan did not contain direction, guidance, or preferences for hospice services, oxygen use, and presence of an indwelling catheter.</p> <p>Review of the resident's Hospice Level of Care sheet, undated, showed the resident elected to receive hospice services on 12/21/24.</p> <p>Review of the resident's POS, dated March 2025, showed:</p> <p>-Check and record oxygen level twice daily;</p> <p>-Change and date oxygen and nebulizer tubing weekly on Saturday;</p> <p>-Oxygen at three liters per minute by nasal cannula continuous for shortness of breath;</p> <p>-Cleanse around catheter site with wound cleanser, apply gauze and secure with tape, change daily and as needed.</p> <p>Observation on 03/03/25 at 10:46 A.M., showed the resident with a catheter draining to gravity, oxygen on at three liters per minute by nasal cannula, and a hospice worker at the bedside.</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  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Rest Haven Health Care Center		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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>7. Review of Resident #25's Annual MDS, dated [DATE], showed staff assessed the resident as follows:</p> <ul style="list-style-type: none"> <li>-Severe cognitive impairment;</li> <li>-Indwelling catheter;</li> <li>-Diagnosis of benign prostatic hyperplasia, neurogenic bladder, quadriplegia, and cerebral palsy.</li> </ul> <p>Review of the resident's care plan, dated 11/10/24, showed the care plan did not contain direction for the following:</p> <ul style="list-style-type: none"> <li>-Enhanced barrier precautions related to indwelling super pubic catheter;</li> <li>-Care for super pubic catheter;</li> <li>-Replacement of size 14 French catheter tubing.</li> </ul> <p>Review of the resident's POS, dated 01/09/25, showed the resident had an order to change supra pubic catheter once a month on the 5th of every month using a size 14 French catheter tube with 10 cubic centimeters (cc) bulb.</p> <p>8. Review of resident #45's Quarterly MDS, dated [DATE], showed staff assessed the resident as follows:</p> <ul style="list-style-type: none"> <li>-Severe cognitive impairment;</li> <li>-No recent falls;</li> <li>-Diagnosis of Alzheimer's, dementia, and stroke.</li> </ul> <p>Review of the resident's Hospice Level of Care, undated, showed the resident started hospice services on 02/27/25.</p> <p>Review of the resident's Fall Risk assessment, dated 12/22/24, showed:</p> <ul style="list-style-type: none"> <li>-The resident had one to two falls in the last three months;</li> <li>-Had intermittent confusion;</li> <li>-poor vision;</li> <li>-Ambulatory;</li> <li>-High risk of falling.</li> </ul> <p>Review of the resident's Elopement Evaluation, dated 12/24/24, showed:</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  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Rest Haven Health Care Center		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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-History of wandering;</p> <p>-Wanders aimlessly;</p> <p>-High risk for elopement.</p> <p>Review of the resident's nurse note, dated 2/1/0/25, showed the resident found on the floor in his/her bedroom and the resident stated he/she had hit his/her head. Resident sent via emergency medical services to the hospital. Administrator notified and asked for a fall mat and bed alarm for the resident.</p> <p>Review of the resident's Progress notes, dated 02/12/25, showed the resident returned from the hospital with a left hip fracture.</p> <p>Review of the resident's care plan, dated 08/04/24, showed:</p> <p>-Did not contain direction for hospice services;</p> <p>-Did not contain intervention or direction for elopement risks;</p> <p>-Did not contain interventions to prevent falls after an actual fall with injury.</p> <p>9. Review of resident #258's Entry track record MDS, showed an admitted [DATE].</p> <p>Review of the resident's medical record, dated 03/06/25, showed the record did not contain a comprehensive care plan.</p> <p>10. During an interview on 03/05/25 at 2:33 P.M., Licensed Practical Nurse/Activity Director (LPN/AD) said he/she was in charge of care plans previously but moved to his/her new position in December. He/She said they had another nurse in that position, but he/she is no longer an employee.</p> <p>During an interview on 03/05/25 at 2:39 P.M., the Chief Nursing Officer said the Regional Nurse is currently acting as the MDS Coordinator due to the recent MDS nurse leaving.</p> <p>During an interview on 03/06/25 at 7:10 A.M., the Interim Director of Nursing (DON) said the corporate nurse completed the care plans and MDS. He/She will send notes to the facility when something needs to be done for the assessments. He/She does not know if the care plans are tailored to the residents but would like to see a background, goals/preferences, discharge needs and generally personalized to the resident. Currently the corporate nurse is the only one updating the care plans and the DON does not have time to read them to know if they are personalized and/or complete. The DON expects the care plans to include hospice, oxygen, falls and adl needs so the staff know how to care for the residents.</p> <p>During an interview on 03/06/25 at 11:43 A.M., the Assistant Director of Nursing (ADON) said they have someone from corporate over seeing the care plans, but they do not have anyone in the facility doing them. The ADON said the nurses do not do care plans or add to them. He/She said they can notify himself/herself about updates that are needed or notify the District MDS coordinator to update them.</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  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Rest Haven Health Care Center		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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 03/06/25 at 12:27 P.M., the District MDS Coordinator said he/she does the assessments and covers the care plans for the facility but the care plans Interdisciplinary Team (IDT) care plans with facility staff. He/She said the staff should meet every quarter to discuss the resident and plan together the care needs of the resident but it is not in place yet since the facility does not have staff to fulfill the MDS role. The MDS Coordinator said if the facility does not tell him/her of changes in resident care or needs, he/she does not know to update the care plan.</p> <p>During an interview on 03/06/25 at 12:36 P.M., the administrator said that care plans should be done by the DON and include things like dialysis, hospice, tube feedings, catheters and other requirements of care. He/She is interim and only been at the facility a few days.</p> <p>47193</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  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Rest Haven Health Care Center		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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43327</p> <p>Based on observation, interview, and record review, facility staff failed to provide services to meet professional standards when staff failed to document and obtain orders for hospice services on two (Resident #18 and #45) of three residents who receive hospice services, to obtain orders for an indwelling catheter for three (Resident #12, #13, and #18) out of three sampled residents, failed to document weekly skin assessments for three (Resident #9, #12, and #13) of six sampled residents and failed to document a smoking assessment on one (Resident #9) of five residents who smoked. The facility census was 52.</p> <p>1. Review of the Coordination of Hospice Services policy, dated 05/18/24, showed the policy did not contain direction to obtain a physician order for hospice.</p> <p>Review of the facility's Indwelling and Suprapubic Catheter Use and Removal policy, dated 06/26/24, showed:</p> <ul style="list-style-type: none"> <li>-If an indwelling catheter is in use, the facility will provide appropriate care for the catheter in accordance with current professional standards of practice and resident care policies and procedures;</li> <li>-Identification and documentation of clinical indications for use of the catheter;</li> <li>-Care and maintenance of suprapubic catheters shall be accordance with physician orders. The orders shall specify the type and size of catheter, and frequency of changes.</li> </ul> <p>Review of the facility's Pressure Injury Prevention and Management policy, dated 05/18/24, showed licensed nurses will conduct full body assessment on all residents weekly and after any newly identified pressure injury.</p> <p>Review of the facility's Smoking Assessment policy, dated 06/29/24, showed:</p> <ul style="list-style-type: none"> <li>-Upon admission and quarterly, the resident will be determined if they are a smoker or a non-smoker;</li> <li>-The RN/LPN will complete the Resident Smoking Assessment to provide the facility with information necessary to determine if the resident is physically able to maintain safety of themselves and others.</li> </ul> <p>2. Review of Resident #18's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 02/11/25, showed staff assessed the resident as:</p> <ul style="list-style-type: none"> <li>-Cognitively intact;</li> <li>-On hospice;</li> <li>-Presence of an indwelling catheter;</li> </ul> <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  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Rest Haven Health Care Center		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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Diagnosis of hemiplegia (paralyzed on one side) and dementia.</p> <p>Review of the resident's Physician Order Sheet (POS), dated March 2025, showed the record did not contain an order for hospice services or an order for the catheter, reason for the catheter, size of the catheter, or the balloon size of the catheter.</p> <p>Review of the resident's Hospice Level of Care sheet, undated, showed the resident admitted to hospice on 12/21/24.</p> <p>Observation on 03/03/25 at 10:46 A.M., showed hospice staff at the resident's bedside and a catheter dignity bag attached to the bedframe draining to gravity.</p> <p>3. Review of Resident #45's Quarterly MDS, dated [DATE], showed staff assessed the resident as follows:</p> <p>-Severe cognitive impairment;</p> <p>-Diagnosis of Alzheimer's, dementia, and stroke.</p> <p>Review of the resident's Hospice Level of Care, undated, showed the resident started hospice services on 02/27/25.</p> <p>Review of the resident's POS, dated 03/06/25, showed the record did not contain orders for hospice services.</p> <p>4. Review of Resident #12's Annual MDS, dated [DATE], showed staff assessed the resident as:</p> <p>-Cognitively intact;</p> <p>-Presence of an indwelling catheter.</p> <p>-No risk for skin breakdown;</p> <p>-Diagnosis of diabetes, peripheral vascular disease (narrowing of arteries and veins that restrict blood flow to the limbs), and bilateral above knee amputation.</p> <p>Review of the resident POS, dated March 2025, showed the orders did not contain an order for the catheter, reason for the catheter, size of the catheter, or the balloon size of the catheter.</p> <p>Review of the resident's medical record, showed the record did not contain documentation of skin assessments for the weeks of 12/01/24, 12/08/24, 12/29/2024 and 01/05/2025.</p> <p>Observation on 03/04/25 at 8:38 A.M., showed the resident in bed with a catheter drainage bag attached to the bed frame.</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  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Rest Haven Health Care Center		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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 03/04/25 at 8:38 A.M., the resident said he/she has had a catheter for a long time and goes to an outside physician monthly to get it changed. He/She had a wound to their bottom that was being treated by an outside physician. He/She said the staff check his/her skin during showers but does not always get his/her showers so they can't be checking his/her skin.</p> <p>5. Review of Resident #13's Quarterly MDS, dated [DATE], showed staff assessed the resident as:</p> <ul style="list-style-type: none"> <li>-Cognitively impaired;</li> <li>-Presence of an indwelling catheter.</li> <li>-At risk for skin breakdown;</li> <li>-Presence of an unhealed pressure ulcer and two arterial/venous ulcers;</li> <li>-Diagnosis of diabetes, peripheral vascular disease, and dementia.</li> </ul> <p>Review of the resident's POS, dated March 2025, showed the orders did not contain an order for the catheter, reason for the catheter, size of the catheter, or the balloon size of the catheter.</p> <p>Review of the resident's medical record showed the record did not contain documentation of skin assessments for the weeks of 01/05/25, 01/12/25, 01/19/25, 01/26/25, 02/02/25 and 02/16/2025.</p> <p>Observation on 03/03/25 at 10:36 A.M., showed the resident with an indwelling catheter draining to gravity hooked to the bottom of his/her wheelchair.</p> <p>6. Review of Resident #9's Quarterly MDS, dated [DATE], showed staff assessed the resident as:</p> <ul style="list-style-type: none"> <li>-Cognitively intact;</li> <li>-admitted on [DATE];</li> <li>-Had impaired vision and functional limitation to one upper extremity;</li> <li>-At risk for developing a pressure ulcer;</li> <li>-Diagnosis of stroke.</li> </ul> <p>Review of the resident's annual MDS, dated [DATE], showed staff assessed the resident as used tobacco.</p> <p>Review of the resident's medical record, showed the record did not contain a completed and documented weekly skin assessment or smoking assessment.</p> <p>Observation on 03/04/25 at 3:33 P.M., showed the resident in the designated smoking area with a smoke apron on his/her chest and smoked a cigarette with staff supervision.</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  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Rest Haven Health Care Center		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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 03/03/25 at 2:33 P.M., the resident said he/she smokes cigarettes and has since admission. He/She said staff supervises them and lights their cigarette for them. He/She does not know if an assessment was completed or not. The resident said he/she does not have any skin breakdown that he/she is aware of.</p> <p>7. During an interview on 03/06/25 at 11:29 A.M., the Assistant Director of Nursing (ADON) said there are three residents currently on hospice services. He/She has only been in the facility since February and has not had any training but would expect there to be orders for hospice.</p> <p>During an interview on 03/06/25 at 7:10 A.M., the Director of Nuring (DON) said nurses are to get orders for hospice. He/She was not aware the residents did not have orders. The nurses are to get orders for catheters to include the reason the resident needs them. He/She was not aware the residents did not have orders. Nurses are to complete skin assessments weekly and if a new wound is noticed to document the wound to include measurements. He/She was not aware the residents were missing some skin assessments. The DON said nurses are responsible to complete smoking assessments on all residents who smoke on admission for safety reasons. He/She was not aware the smoking assessment was not completed.</p> <p>During an interview on 03/06/25 at 12:36 P.M., the administrator said residents should have an order obtained by nursing for hospice services. He/She is new to the building and was not aware the orders were not in place. The DON is responsible for oversight of the nursing staff and would expect there to be orders for catheters and why the resident has one. The nursing staff are required to complete skin assessments weekly in the electronic health record. He/She said the DON is responsible to ensure the assessments are completed. He/She is new to the building and was not aware the assessments were not documented. The administrator said residents have a smoking assessment completed on admission and quarterly by the nursing staff. He/She is new to the building and was not aware the assessment was not documented in the resident record.</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  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Rest Haven Health Care Center		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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40424</p> <p>Based on observation, interview, and record review, facility staff failed to provide care to meet basic hygiene needs for five sampled residents (Resident #11, #12, #13, #27, and #42,). The facility census was 52.</p> <p>1. Review of the facility's Activities of Daily Living (ADL) policy, dated 05/18/24, showed:</p> <ul style="list-style-type: none"> <li>-The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADL's do not deteriorate unless deterioration is unavoidable;</li> <li>-Care and services will be provided for the following ADL's, toileting, bathing, dressing, grooming and oral care.</li> </ul> <p>Review of the facility's Resident Showers policy, dated 06/26/24, showed:</p> <ul style="list-style-type: none"> <li>-It is the practice of this facility to assist residents with bathing to maintain proper hygiene, stimulate circulation and help prevent skin issues as per standards of practice;</li> <li>-Residents will be provided showers as per request or as per facility schedule protocols and based upon resident safety;</li> <li>-Partial baths may be given between regular shower schedules as per facility policy.</li> </ul> <p>2. Review of Resident #11's Annual Minimum Data Set (MDS), a federally mandated assessment tool, dated 02/08/25, showed staff assessed the resident as:</p> <ul style="list-style-type: none"> <li>-Cognitive intact;</li> <li>-Bathing substantial assistance;</li> <li>-Personal hygiene substantial assistance;</li> <li>-Diagnosis of alzheimers, dementia, seizure disorder, and anxiety.</li> </ul> <p>Observation on 03/03/25 at 2:46 P.M., showed the resident in bed with greasy appearing hair.</p> <p>Observation on 03/05/25 at 10:52 A.M., showed the resident in bed with greasy appearing hair.</p> <p>3. Review of Resident #12's Annual MDS, dated [DATE], showed staff assessed the resident as:</p> <ul style="list-style-type: none"> <li>-Cognitively intact;</li> <li>-Required substantial/maximum assistance with showers/bathing;</li> </ul> <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  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Rest Haven Health Care Center		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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Diagnosis of bilateral above knee amputation and diabetes.</p> <p>Review of the resident's care plan, dated 12/11/24, showed the care plan did not contain direction or preferences for showers or ADL's.</p> <p>Observation on 03/03/25 at 11:21 A.M., showed the resident with greasy unkempt hair and long fingernails.</p> <p>Observation on 03/04/25 at 08:38 A.M., showed the resident with greasy hair and long fingernails.</p> <p>During an interview on 03/04/25 at 08:38 A.M., the resident said he/she was supposed to get a shower yesterday but didn't. He/She is going to the doctor today and now have to go dirty. The resident said he/she is embarrassed to have the physician see him/her like that. He/She said showers are usually once a week but sometimes go even longer and a waste of time to complain about it, because they pull the shower aid to work the floor all the time.</p> <p>4. Review of Resident #13's Quarterly MDS, dated [DATE], showed staff assessed the resident as:</p> <p>-Cognitively impaired;</p> <p>-Dependent on staff for hygiene and showers;</p> <p>-Diagnosis of dementia.</p> <p>Review of the resident's care plan, dated 08/06/24, showed the resident is dependent on one staff for personal hygiene.</p> <p>Observation on 03/03/25 at 10:36 A.M., showed the resident with long facial hair, unkempt hair, and long fingernails.</p> <p>Observation on 03/04/25 at 07:56 A.M., showed the resident in the dining room with long facial hair, unkempt hair, and long fingernails.</p> <p>Observation on 03/04/25 at 08:49 A.M., showed the resident at the nurse station with long facial hair, long fingernails and unkempt hair.</p> <p>Observation on 03/05/25 at 08:30 A.M., showed the resident at the nurse station with long fingernails, unkempt hair and long facial hair.</p> <p>5. Review of Resident #27's Quarterly MDS, dated [DATE], showed staff assessed the resident as:</p> <p>-Cognitively impaired;</p> <p>-Dependent with all care;</p> <p>-Diagnosis of dementia.</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  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Rest Haven Health Care Center		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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's care plan, dated 01/23/25, showed the care plan did not contain direction or guidance or preferences for ADL's.</p> <p>Review of the resident's shower sheets, dated January through March, showed staff documented the resident received a shower on the following:</p> <ul style="list-style-type: none"> <li>-January 31, 2025;</li> <li>-February 4, 13, 18 and 20, 2025;</li> <li>-Did not contain documentation for the month of March</li> </ul> <p>Observation on 03/03/25 at 11:03 A.M., showed the resident with long facial hair, long finger nails with a dark substance under them, and unkempt hair.</p> <p>6. Review of Resident #42's Annual MDS, dated [DATE], showed staff assessed the resident as:</p> <ul style="list-style-type: none"> <li>-Moderate cognitive impairment;</li> <li>-Bathing total dependence;</li> <li>-Personal Hygiene moderate assistance;</li> <li>-Diagnosis of arthritis, alzheimers, dementia, and anxiety.</li> </ul> <p>Observation on 03/03/25 at 2:50 P.M., showed the resident in bed with greasy hair.</p> <p>Observation on 03/05/35 at 10:53 A.M., showed the resident in bed with greasy hair.</p> <p>During an interview on 03/05/25 at 10:55 A.M., the resident said he/she can comb their hair and brush my teeth sometimes but not always. Staff here don't help me and they don't seem to care about us. The resident said it brings him/her to tears.</p> <p>7. During an interview on 03/04/25 at 11:30 A.M., Nurse Aide (NA) E said there is not enough staff to get everything done in the day but they do the best they can. Showers are supposed to be twice a week, but the shower aide has to get pulled to the floor to help. He/She said if there was more staff to do it, then it wouldn't be so hard to get it done. Shaves and nails should be cut with showers.</p> <p>During an interview on 03/06/25 at 7:46 A.M., the Director of Nursing (DON) said a residents hair should be combed, face washed, fingernails cleaned, and shaved when needed. Aids and nursing staff are responsible for ensuring this gets done. He/She said they were aware some residents are not having this done for them and ultimately the charge nurses and DON are responsible for making sure staff are educated to help with showers and hygiene.</p> <p>During an interview on 03/06/25 at 9:12 A.M. Certified Nurse Aid (CNA) K said showers should be done twice a week, staff are not able to keep up with the schedule. He/She said there should no excuses for a resident's hair not being combed if needed.</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  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Rest Haven Health Care Center		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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 03/06/25 at 9:21 A.M., Licensed Practical Nurse (LPN) A said residents should be showered twice a week but staff don't always get them done due to low staffing. All grooming assistance should be done before a resident leaves their room or as needed.</p> <p>During an interview on 03/06/25 at 1:08 P.M., the administrator said residents should be groomed in the morning and throughout the day. Showers should be on a regular basis. He/She said they were not sure how well this is getting done.</p> <p>43327</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  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Rest Haven Health Care Center		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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>40424</p> <p>Based on observation, interview, and record review, facility staff failed to lock medication carts when unattended and failed to safely store hazardous materials in a manner to prevent accidents in two of three shower rooms. The facility census was 52.</p> <p>1. Review of the facility's Medication Storage policy, dated 05/18/24, showed:</p> <p>-All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls;</p> <p>-During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart.</p> <p>2. Observation on 03/03/25 at 11:28 A.M., showed the medication cart at the nurse station unlocked and unattended. Observation showed residents in the hall near the nurses station.</p> <p>Observation on 03/05/25 at 8:36 A.M., showed the Director of Nursing (DON) left the medication cart unlocked and unattended at the nurses' station.</p> <p>Observation on 03/05/25 11:50 A.M., showed the medication cart at the nurse station unlocked and unattended and insulin pen sat on top of the medication cart.</p> <p>Observation on 03/06/25 at 4:51 A.M., showed the medication cart at the nurse station unlocked and unattended.</p> <p>During an interview on 03/06/25 at 7:10 A.M., the DON said staff should lock the medication cart if walking away from it. He/She said the facility has confused residents that could get into it and eat something they are not supposed to have. The DON said the person working with the cart is responsible to ensure the cart is locked when leaving the cart. He/She did not know why he/she left the cart unlocked and unattended.</p> <p>During an interview on 03/06/25 at 9:55 A.M., Certified Medication Technician (CMT) B said staff should lock medication carts when they are not using them, and medication should not be left on top of carts. He/She said there is a risk that residents could get into the unlocked carts and take medications that could be harmful.</p> <p>During an interview on 03/06/25 at 11:17 A.M., Licensed Practical Nurse (LPN) A said it is the responsibility of the CMT or nurse to ensure medication carts are locked when unattended and medications are put away. He/She said it is a safety risk to residents who may get into the medications.</p> <p>3. Review of the facility's Chemical Storage and Labeling policy, dated 02/02/24, showed:</p> <p>-The chemical storage room must remain locked at all times when someone is not in the storage room;</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  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Rest Haven Health Care Center		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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Hazardous chemicals must be separated from non-hazardous chemicals.</p> <p>Review of the facility's Nursing Environmental Inspection Policy, dated 06/26/24 showed:</p> <p>-The DON or designee will perform random and/or routine inspections of the nursing environment. These areas will consist of, but is not limited to, shower rooms;</p> <p>-Environmental inspections should include the cleanliness of the area as well as ensuring the areas are free of any potentially dangerous risks/items.</p> <p>4. Observation on 03/03/25 at 10:34 A.M., showed 200 hall shower room unlocked and unattended. The shower room contained open packages of disposable razors, an unlocked cabinet with a bottle of lime remover, an aerosol can labeled WD40, a container labeled disinfectant wipes and a plastic cart contained resident care supplies with white dust on the surface and handles.</p> <p>Observation on 03/04/25 at 8:09 A.M., showed 200 hall shower room unlocked and unattended. The shower room contained open packages of disposable razors, an unlocked cabinet with a bottle of lime remover, an aerosol can labeled WD40, a container labeled disinfectant wipes and a plastic cart contained resident care supplies with white dust on the surface and handles.</p> <p>Observation on 03/05/25 at 08:30 A.M., showed 200 hall shower room unlocked and unattended. The shower room contained open packages of disposable razors, an unlocked cabinet with a bottle of lime remover, an aerosol can labeled WD40, a container labeled disinfectant wipes and a plastic cart contained resident care supplies with white dust on the surface and handles.</p> <p>5. Observation on 03/03/25 at 2:00 P.M., showed the 100 hall shower room unlocked with the door propped open and unattended. The shower room contained an unlocked cabinet with an open box of disposable razors.</p> <p>Observation on 03/04/25 at 02:05 P.M., showed the 100 hall shower room unlocked with the door propped open and unattended. The shower room contained an unlocked cabinet with an open box of disposable razors.</p> <p>Observation on 03/05/25 at 10:00 A.M., showed the 100 hall shower room unlocked with the door propped open and unattended. The shower room contained an unlocked cabinet with an open box of disposable razors.</p> <p>6. During an interview on 03/06/25 at 07:10 A.M., the DON said the shower room on the 200 hall had a key lock on it and was not aware it had been unlocked during the survey. He/She said chemicals and hazards should be kept in a locked cabinet in the shower room and the shower room should be locked when unattended or residents could get in there and get hurt.</p> <p>During an interview on 03/06/25 at 9:12 A.M., Certified Nurse Aid (CNA) K said the shower rooms doors should be locked so residents can't access hazardous materials. They could be injured.</p> <p>During an interview on 03/06/25 at 9:20 A.M., LPN A said showers are to be locked when not in use. If the doors are not locked a resident could come in contact with chemicals and be hurt.</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  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Rest Haven Health Care Center		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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 03/06/25 at 12:36 P.M., the administrator said shower rooms are key-coded and should be locked when unattended and includes the cabinets inside the shower rooms. He/She said if chemicals or hazards are stored in the shower rooms, the rooms should be locked and the chemicals/hazards should be kept in a locked cabinet.</p> <p>43327</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  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Rest Haven Health Care Center		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 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>40424</p> <p>Based on observation, interview, and record review, facility staff failed to provide thorough orders, monitoring, and ongoing communication with the dialysis (a treatment that cleans the blood when the kidneys fail to function properly) clinic for one of one resident (Resident #48). The facility census was 52.</p> <p>1. Review of the facility's Dialysis policy, dated 03/18/22, showed the following:</p> <ul style="list-style-type: none"> <li>-Ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility;</li> <li>-Ongoing assessment and oversight of the resident before and after dialysis treatments;</li> <li>-Ongoing communication and collaboration with the dialysis clinic, regarding dialysis care and services;</li> </ul> <p>a. Coordination of physician services between the nursing facility and dialysis facility. For a resident receiving dialysis, the nursing home staff must immediately contact and communicate with the attending physician/practitioner, resident/resident representative, and designated dialysis staff regarding any significant changes in the resident's status related to clinical complications or emergent situations that may impact the dialysis portion of the care plan.</p> <p>b. Theses situations may include but are not limited to changes in cognition or sudden unexpected decline in condition, dialysis complications such as bleeding, hypertension, or adverse consequences to a dedication or therapy, or other situations.</p> <p>c. Any changes in the resident's care initiated by the dialysis facility must be communicated to the resident's nursing home attending physician/practitioner.</p> <p>2. Review of Resident #48's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 02/18/25, showed facility staff assessed the resident as follows:</p> <ul style="list-style-type: none"> <li>-Intact Cognition;</li> <li>-Received dialysis while a resident;</li> <li>-Diagnosis of renal failure and diabetes mellitus.</li> </ul> <p>Review of the resident's Physician Order Sheet (POS), dated 11/21/24, showed the POS did not contain orders related to dialysis.</p> <p>Review of the resident's care plan, dated 07/16/24, showed the record did not contain direction for dialysis.</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  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Rest Haven Health Care Center		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 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of residents medical record did not contain documentation staff assessed the resident prior to being transported to dialysis.</p> <p>During an interview on 03/04/25 at 9:53 A.M., the resident said the facility staff does not assess him/her before they go to dialysis but the clinic does when he/she is at the appointment.</p> <p>During an interview on 03/05/25 Licensed Practical Nurse (LPN) J said staff do not assess the resident prior to transport to the dialysis clinic. He/She said what records the facility have are provided by the dialysis clinic.</p> <p>During an interview on 03/06/25 at 6:58 A.M., LPN A said we do not check vitals before a resident goes to dialysis. Staff are to make sure the resident is ready to go and has some food.</p> <p>During an interview on 03/06/25 at 7:11 A.M., the Director of Nursing (DON) said we should be doing vital signs before a resident goes to dialysis but we don't because the clinic does. Staff also don't check the resident when they return to the facility but we probably should.</p> <p>During an interview on 03/06/25 at 12:30 P.M., the Regional MDS director said dialysis should be on the care plan and included in the POS upon admission.</p> <p>During an interview on 03/06/25 at 12:48 P.M., the administrator said dialysis should be on the POS and must be care planned. Staff should take a set of vitals before transport because it is a risk to the resident not to do so if they are ill.</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  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Rest Haven Health Care Center		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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43327</p> <p>Based on observation, interview and record review, the facility failed to provide services by sufficient numbers of nurse aides to provide nursing care to eight of 14 sampled residents (Resident #11, #12, #13, #25, #27, #31, #33, and #42) to ensure care and comfort of residents daily needs. The facility census was 52.</p> <p>1. Review of the resident council meeting notes for December 2024, January 2025, and February 2025, showed the residents expressed concern for lack of staff, staff not answering call lights at night, staff not making the beds, night shift working with only one nurse for the entire building, not receiving ice water every shift and not enough aides to work on the 100 hall.</p> <p>Review of the facility's nurse staff punch detail dated 02/17/25 through 03/05/25 showed:</p> <p>-One licensed nurse and one certified nurse aide (CNA) on duty from 10:49 P.M. to 5:43 A.M. on 02/23/25 with a census of 57 residents;</p> <p>-One licensed nurse and one CNA on duty from 09:33 P.M. to 11:46 P.M., on 02/24/25 with a census of 57 residents;</p> <p>-One licensed nurse and one CNA on duty from 11:13 P.M. to 5:49 A.M., on 02/25/25 with a census of 55 residents;</p> <p>-One licensed nurse and one CNA on duty from 11:24 P.M. to 5:49 A.M on 02/28/25 with a census of 52.</p> <p>2. Review of Resident #11's Annual Minimum Data Set (MDS), a federally mandated assessment tool, dated 02/08/25, showed staff assessed the resident as:</p> <p>-Cognitive intact;</p> <p>-Bathing substantial assistance;</p> <p>-Personal hygiene substantial assistance;</p> <p>-Diagnosis of alzheimers, dementia, seizure disorder, and anxiety.</p> <p>Observation on 03/03/25 at 2:46 P.M., showed the resident in bed with greasy appearing hair.</p> <p>Observation on 03/05/25 at 10:52 A.M., showed the resident in bed with greasy appearing hair.</p> <p>3. Review of Resident #12's Annual MDS, dated [DATE], showed staff assessed the resident as:</p> <p>-Cognitively intact;</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  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Rest Haven Health Care Center		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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Required substantial/maximum assistance with showers/bathing;</p> <p>-Diagnosis of bilateral above knee amputation and diabetes.</p> <p>Review of the resident's care plan, dated 12/11/24, showed the care plan did not contain direction or preferences for showers or Activities of Daily Living (ADL)'s.</p> <p>Observation on 03/03/25 at 11:21 A.M., showed the resident with greasy unkempt hair and long fingernails.</p> <p>Observation on 03/04/25 at 8:38 A.M., showed the resident with greasy hair and long fingernails.</p> <p>During an interview on 03/04/25 at 08:38 A.M., the resident said he/she is lucky to get one shower a week and could be even longer at times. He/She said the facility has to pull the shower aide to help on the floor so showers don't get done. The resident said he/she had to go to the doctor stinky. Night shift is really lacking on staff sometimes only having one aide and one nurse in the whole building leaving residents wet in their beds. The nurses get mad when they have to pass their own medications if the medication technician has to work to help the aides or just don't come in at all.</p> <p>4 Review of Resident #13's Quarterly MDS, dated [DATE], showed staff assessed the resident as:</p> <p>-Cognitively impaired;</p> <p>-Dependent on staff for hygiene and showers;</p> <p>-Diagnosis of dementia.</p> <p>Review of the resident's care plan, dated 08/06/24, showed the resident is dependent on one staff for personal hygiene.</p> <p>Observation on 03/03/25 at 10:36 A.M., showed the resident with long facial hair, unkempt hair, and long fingernails.</p> <p>Observation on 03/04/25 at 7:56 A.M., showed the resident in the dining room with long facial hair, unkempt hair, and long fingernails.</p> <p>Observation on 03/04/25 at 8:49 A.M., showed the resident at the nurse station with long facial hair, long fingernails and unkempt hair.</p> <p>Observation on 03/05/25 at 8:30 A.M., showed the resident at the nurse station with long fingernails, unkempt hair and long facial hair.</p> <p>5. Review of Resident 25's Annual MDS, dated [DATE], showed staff assessed the resident as:</p> <p>-Cognitively impaired;</p> <p>-dependent on staff for all care;</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  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Rest Haven Health Care Center		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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Always incontinent;</p> <p>-Presence of an indwelling catheter;</p> <p>-Diagnosis of quadriplegia.</p> <p>Observation on 03/05/25 at 12:00 P.M., showed the resident saturated through his/her sheets to the mattress and smelled strongly of urine.</p> <p>6. Review of Resident #27's Quarterly MDS, dated [DATE], showed staff assessed the resident as:</p> <p>-Cognitively impaired;</p> <p>-Dependent with all care;</p> <p>-Diagnosis of dementia.</p> <p>Review of the resident's care plan, dated 01/23/25, showed the care plan did not contain direction or guidance or preferences for ADL's.</p> <p>Observation on 03/03/25 at 11:03 A.M., showed the resident with long facial hair, long finger nails with a dark substance under them, and unkempt hair.</p> <p>7. Review of Resident #31's Quarterly MDS, dated [DATE] showed staff assessed the resident as:</p> <p>-Cognitively impaired;</p> <p>-Required supervision with toileting;</p> <p>-Required substantial/maximum assistance for showers;</p> <p>-Diagnosis of dementia.</p> <p>Observation on 03/03/25 at 11:33 A.M., showed the resident fingernails long with debris under them, unkempt hair, and long facial hair.</p> <p>Observation on 03/03/25 at 12:14 P.M., showed the resident in the dining room, during the noon meal with visibly wet pants and smelled of urine.</p> <p>Observation on 03/05/25 at 1:15 P.M., showed the resident propelled from the dining room, with visibly wet pants, unkempt hair, long fingernails and long facial hair.</p> <p>8. Review of Resident #33's Quarterly MDS, dated [DATE], showed staff assessed the resident as:</p> <p>-Cognitively impaired;</p> <p>-Required partial to moderate assistance for toilet hygiene;</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  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Rest Haven Health Care Center		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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Always incontinent of urine;</p> <p>-Diagnosis of dementia and stroke.</p> <p>Observation on 03/06/25 at 4:52 A.M., showed the resident saturated through his/her sheets to the mattress and smelled strongly of urine.</p> <p>9. Review of Resident #42's Annual MDS, dated [DATE], showed staff assessed the resident as:</p> <p>-Moderate cognitive impairment;</p> <p>-Bathing total dependence;</p> <p>-Personal Hygiene moderate assistance;</p> <p>-Diagnosis of arthritis, alzheimers, dementia, and anxiety.</p> <p>Observation on 03/03/25 at 2:50 P.M., showed the resident in bed with greasy hair.</p> <p>Observation on 03/05/35 at 10:53 A.M., showed the resident remained in bed with greasy hair.</p> <p>When was the last shower? - info was not obtained.</p> <p>10. During an interview on 03/03/25 at 2:33 P.M., Resident #9 said there isn't enough staff on the night shift. Most of the time, there is only one aide and if they work the other side of the building, there is no one to hear the call lights or if there is an issue. Residents have to sit in their own piss in bed for over two hours because they don't check on us. Showers are not getting done like they are supposed to twice a week. Residents are lucky to get one shower a week. He/She said there is no administrator to go to and even if they did, nothing would get done except makes things worse. The staff that they do have, do not have time to put pads on the bed or strip and wash the linens so they smell bad. The only way I get attention is if I pull the call light out of the wall but even then it will take two to three hours to get them to come. Sometimes we are late going out for supervised smoke break because we need to wait for an available staff member to take us and the nurse is always to busy to help the aides. There are some good aides that are going to quit because they are worn ragged.</p> <p>During an interview on 03/04/25 at 9:11 A.M., the resident council group said there is a lot of staff here just for a paycheck and just don't care. The facility needs to hire more aides. The residents said that some residents have to lay in their urine at night and sometimes resident get sick and need to be sent to the hospital and it's because there isn't enough staff to watch over them. What is hired don't always work out and don't come back because they are overwhelmed. A lot of night shift staff come in and turn off the call lights and disappear or just sit at the desk and play on their phones or talk loudly. The group stated that there are two licensed nurses that they fear cannot physically do the job and makes them nervous. One of the nurses cannot even walk.</p> <p>During an interview on 03/04/25 at 09:44 A.M., Resident #8 said it takes at least 30 minutes or more to have his/her call light answered, meals are often late and/or cold and he/she does not get his/her showers like he should at least twice a week which makes him feel disgusting.</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  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Rest Haven Health Care Center		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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview 03/04/25 at 11:02 A.M., Nurse Aide (NA) D said we have two aids and one nurse on overnights shifts normally and we do our best to keep up with resident needs. He/She said the overnight shift has to wait for morning staff to show up to help get residents up for the day otherwise all we can do is try to keep them clean and dry overnight.</p> <p>During an interview on 03/04/25 at 11:30 A.M., NA D said there is not enough staff and what they hire do not stay because either they don't like it or its too hard. Aides don't have time to stock up on supplies and when they need something, the aide will have to take time away from providing care such as assisting with meals or care for another resident to go get supplies. He/She said there is usually enough staff in the daytime, but still not enough to get everyone checked in two hours. If they cannot check everyone in two hours, they could have a big mess and cause skin irritation and wounds, then would have to wait for the nurse to come and assess it putting us further behind. There is a shower aide, but they are always pulled to the floor so showers don't get done. If there was more staff, then the aides could help with the showers so the residents aren't laying in filth or getting depressed. Call lights should be answered in three to five minutes, sometimes if we are by ourselves on the hall, multiple lights go off at the same time and we just do the best we can. If there is a resident who is a mechanical lift, then that is more time looking for someone to assist with that transfer. The aides do not always get help from the nurse or medication technicians.</p> <p>During an interview on 03/05/25 at 2:43 P.M., the Chief Nursing Officer said the facility has been having some staffing issues. He/She said the facility's Administrator, Director of Nursing (DON), and other nurses/staff recently walked out and quit.</p> <p>During an interview on 03/06/25 at 04:52 A.M., Certified Nurse Aide (CNA) L said there is not enough staff on the night shift. Usually it's him/her an one other aide for the whole building and it gets really stressful at times. He/She said they try to get everything done, but are unable to always get to everyone in two hours or get anyone up in the morning before the dayshift comes in. We have to split the building and then meet up if there are residents who are heavier or require two people leaving one hall unattended if the nurse is not on it and sometimes delays care even more. Management has been told more staff is needed but when they hire someone, either they quit or just don't come back. There is no skills training or checkoffs and no performance evaluations and if we don't ask about resident care, then the nurses don't tell us.</p> <p>During an interview on 03/06/25 at 5:10 A.M., the Acting DON said he/she was called in at 2:00 A.M. to cover the floor due to nurse leaving for an emergency.</p> <p>During an interview 03/06/25 at 7:10 A.M., the DON said he/she feels like DON is just a title/name he/she was given. He/She said they are short staffed, and he/she has not had time to be a DON because he/she has been acting as a charge nurse and working the floor. He/She said its impossible to keep up with only two aides on the floor. The facility needs to pay staff more and is aware of resident complaints of lack of staff. Residents are not getting showers and shave like they are supposed to at least twice a week, fresh ice water and emotional needs addressed due to lack of staff. He/She said there is no real boss right now to go to for issues or guidance.</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  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Rest Haven Health Care Center		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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 03/06/25 at 09:25 A.M., CNA I said there is very seldom enough staff. The administration has changed and no one asks us about staffing needs anymore. Things like showers, shaves and nail care are getting missed or given late, its hard to check everyone in two hours or less and when coming in after night shift, there is no bags in trash cans or readily available supplies to be able to care for the residents timely. Often when following the nightshift, residents are saturated in their beds and the halls smell of urine. He/She said he/she has not received any skills check offs or evaluations since he has worked at the facility.</p> <p>During an interview on 03/06/25 at 9:55 A.M., CNA B said he/she has not seen the DON perform that role because he/she acts as the charge nurse due to staffing issues. He/She said they had a large number of administrative staff and nurses walk out and they have not been able to hire more staff. He/She said they do not currently have an administrator, acting DON, infection preventionist, MDS coordinator, or a nurse for care plans. He/She said CNA's do not last because they are short staffed as well. He/She said there isn't anyone to implement polices or procedures or to hold people accountable right now. He/She said residents are suffering because medication prior authorizations are not being done, facility supplies do not get ordered, showers often are not completed, and staff education is not being done. He/She said there have been times were night shift only had a nurse and an aide because of call ins. He/She said he/she worries about the resident's safety.</p> <p>During an interview on 03/06/25 at 11:29 A.M., the Assistant DON said he/she is fairly new to the building but came into a schedule without staff and have been trying to build it. He/She said that the facility has lost a lot of nursing staff and most of the time is working just one nurse on dayshift and one on the night shift. The facility is trying to recruit, but the hires start then never show back up. He/She is aware of resident complaints about staffing and has reached out to corporate without a response. The ADON said he/she feels the staff they have do the best they can to meet the needs of the residents but the staff are being stretched to the limit and wearing down. Several residents are not getting showers or only getting one per week. He/She said that there are no skills checkoffs or evaluations that he/she is aware of but puts newly hired staff with the more seasoned or stronger aides for training.</p> <p>During an interview on 03/06/25 at 12:36 A.M., the Acting Administrator said he/she does not feel there is enough staff to complete the hands on care such as showers. He/She said staff are running very thin. He/She said he/she is new to the position and facility and will work with corporate to develop a plan.</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  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Rest Haven Health Care Center		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 0728</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training.</p> <p>43327</p> <p>Based on interview and record review, facility staff failed to ensure four out of six nurse aides ((NA) NA C, NA D, NA E, NA F) completed the nurse aide training program within four months of their employment in the facility. The facility census was 52.</p> <p>1. Review of the facility's Nurse Aide Training policy, dated 05/18/24, showed the policy did not contain NA completion timeline or how to proceed if NA goes beyond the 120 day requirement.</p> <p>Review of the facility's Active Employee list showed:</p> <p>-NA C hired 04/03/24;</p> <p>-NA D hired 07/26/24;</p> <p>-NA E hired 08/30/24;</p> <p>-NA F hired 09/12/24;</p> <p>During an interview on 03/04/25 at 10:00 A.M., NA D said he/she has been working on the floor as an aide for eight months and has not been able to pass the testing required to become certified. He/She has to wait for certified staff or nurses to assist residents with care needs.</p> <p>During an interview on 03/06/25 at 7:10 A.M., the Director of Nursing (DON) said NA's are required to be certified within 120 days of hire. He/She is aware some of the NA's are beyond the required 120 days because they did not pass the test. Nurse Aides are supposed to be pulled into another place such as pass ice water, making beds and not work the floor as a NA but there is not enough staff to cover their spot so the NA have not been moved off the floor.</p> <p>During an interview on 03/06/25 at 12:04 P.M., the Human Resources staff said NA's are to be certified within 120 days. He/She said he/she just took over tracking and is responsible to schedule the testing. If a staff member goes beyond the 120 days and is not certified, the human resources staff said he/she would have to reach out to corporate for guidance.</p> <p>During an interview on 03/06/25 at 12:36 P.M., the administrator said NA's should be certified within four months. If the NA is not certified in the time-frame, they should be removed from that position. He/She is new to the position and said the Human Resources is responsible to ensure compliance with timeframes with coordination from the DON. He/She was not aware the NA's were not certified in the time-frame.</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  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Rest Haven Health Care Center		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 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>47193</p> <p>Based on observation, interview, and record review, facility staff failed to maintain a medication error rate of less than 5% out of 52 opportunities observed, 28 errors occurred, resulting in a 53.85% error rate, which affected three residents (Resident #4, #12, and #258) out of seven sampled residents. The facility census was 52.</p> <p>1. Review of the Facility's Medication Administration policy, revised 06/26/24, showed:</p> <ul style="list-style-type: none"> <li>-General medication administration process:</li> <li>-Ensured that the six rights of medication administration are followed:</li> <li>-Right time;</li> <li>-Compare medication source (bubble pack, vial, etc.) with Medication Administration Record (MAR) to verify resident name, medication name, form, dose, route, and time;</li> <li>-Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by the physician.</li> </ul> <p>2. Review of Resident #4 Physician's Order Sheet (POS), dated 03/05/25, showed:</p> <ul style="list-style-type: none"> <li>-Cetirizine (Antihistamine) 10 milligram (mg) tablet at 6:00 A.M.;</li> <li>-Fluphenazine (Antipsychotic) 5 mg tablet at 6:00 A.M.;</li> <li>-Jardiance (Treatment of type 2 diabetes mellitus) 25 mg tablet at 6:00 A.M.;</li> <li>-Tamsulosin HCL (Treats benign enlarged glands) 0.4 mg capsule at 06:00 A.M.;</li> <li>-Acetaminophen 325 mg tablet give two tablets at 6:00 A.M and 03:00 P.M.;</li> <li>-Levetiracetam (Anticonvulsant) 500 mg tablet at 6:00 A.M. and 7:00 P.M.;</li> <li>-Famotidine (antacid) 20 mg tablet at 06:00 A.M. and 7:00 P.M.;</li> <li>-Metformin (treatment of type 2 diabetes mellitus) 500 mg tablet at 06:00 A.M. and 07:00 P.M.;</li> <li>-Topiramate (Anticonvulsant) 100 mg at 06:00 and 07:00 P.M.;</li> <li>-Vascepa (Antihyperlipidemic) one gram capsule at 06:00 A.M. and 07:00 P.M.</li> </ul> <p>Observation on 03/05/25 at 11:19 A.M., showed Certified Medication Technician (CMT) B administered the following medications (five hours and nineteen minutes after the prescribed time):</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  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Rest Haven Health Care Center		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 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Cetirizine 10 mg tablet;</p> <p>-Fluphenazine 5 mg tablet;</p> <p>-Jardiance 25 mg tablet;</p> <p>-Tamsulosin HCL 0.4 mg capsule;</p> <p>-Acetaminophen 325 mg tablet give two tablets;</p> <p>-Levetiracetam 500 mg tablet;</p> <p>-Famotidine 20 mg tablet;</p> <p>-Metformin 500 mg tablet;</p> <p>-Topirmate 100 mg;</p> <p>-Vascepa one gram capsule.</p> <p>3. Review of Resident #12 POS, dated 03/05/25, showed:</p> <p>-Claritin 10 mg at 6:00 A.M.;</p> <p>-Finasteride (Treats benign enlarged glands) 5 mg at 6:00 A.M.;</p> <p>-Furosemide (Diuretic)20 mg at 6:00 A.M.;</p> <p>-Potassium Chloride ER (Treat low potassium) 10 milliequivalent (mEq) at 6:00 A.M.;</p> <p>-Metformin 500 mg at 6:00 A.M. and 7:00 P.M.;</p> <p>-Oxybutynin Chloride (Treats overactive bladder) 5 mg at 6:00 A.M. and 3:00 P.M.;</p> <p>-Buspirone HCL (antianxiety)10 mg at 6:00 A.M., 11:00 A.M., and 7:00 P.M.;</p> <p>-Gabapentin (Anticonvulsant) 800 mg at 6:00 A.M., 11:00 A.M., and 7:00 P.M.</p> <p>Review of the resident's MAR, dated 03/05/25, showed staff did not document the the resident received the following 6:00 A.M. medications:</p> <p>-Buspirone HCL 10 mg;</p> <p>-Gabapentin 800 mg.</p> <p>Observation on 03/05/25 at 10:57 A.M., showed CMT B administered the following medications (four hours and fifty seven minutes after the prescribed time):</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  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Rest Haven Health Care Center		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 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Claritin 10 mg;</p> <p>-Finasteride 5 mg;</p> <p>-Furosemide 20 mg;</p> <p>-Potassium Chloride ER 10 mEq;</p> <p>-Metformin 500 mg;</p> <p>-Oxybutynin Chloride 5 mg.</p> <p>4. Review of Resident #258 POS, dated 03/05/25, showed:</p> <p>-Clopidogrel (Antiplatelet) 75 mg tablet at 6:00 A.M.;</p> <p>-Ocuvite Adult 50+ Capsule (Multiple Vitamins w/ Minerals) at 6:00 A.M.;</p> <p>-Potassium chloride ER (Treat low potassium) 10 meq at 6:00 A.M.;</p> <p>-Prednisone 10 mg at 6:00 A.M.;</p> <p>-Vitamin B-1 100 mg tablet at 6:00 A.M.;</p> <p>-Brimonidine Tartrate-Timolol Maleate (Treatment of ocular hypertension) 0.2-0.5% at 6:00 A.M. and 7:00 P.M.;</p> <p>-Sulfamethoxazole-Trimethoprim (Antibiotic) 800-160 mg at 6:00 A.M. and 8:00 P.M.;</p> <p>-Torsemide 30 mg (diuretics) at 6:00 A.M. and 3:00 P.M.;</p> <p>-Pentoxifylline ER (treats poor blood circulation/pain) 400 mg at 6:00 A.M., 11:00 A.M., and 7:00 P.M.;</p> <p>-Advair HFA Inhalation Aerosol (Treat asthma) 45-21 MCG/ACT (Fluticasone-Salmeterol) two inhalation inhale at 6:00 A.M. and 7:00 P.M</p> <p>Review of the resident's MAR, dated 03/05/25, showed staff did not document the resident received his/her 6:00 A.M. Pentoxifylline ER 400 mg tablet medication.</p> <p>Observation on 03/05/25 at 11:04 A.M., showed CMT B administered the following medications (five hours and four minutes after the prescribed time):</p> <p>-Clopidogrel 75 mg tablet;</p> <p>-Ocuvite Adult 50+ Capsule;</p> <p>-Potassium chloride ER 10 meq;</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  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Rest Haven Health Care Center		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 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Prednisone 10 mg;</p> <p>-Vitamin B-1 100 mg tablet;</p> <p>-Sulfamethoxazole-Trimethoprim 800-160 mg;</p> <p>-Torsemide 30 mg;</p> <p>-Brimonidine Tartrate-Timolol Maleate 0.2-0.5%;</p> <p>-Advair HFA Inhalation Aerosol 45-21 MCG/ACT (Fluticasone-Salmeterol) 2 inhalation.</p> <p>5. During an interview on 03/05/25 at 10:56 A.M., CMT B said he/she was told he/she has an hour before and an hour after medication time frames to pass medications or they are considered late. He/She said the reason the medication were late was because the electricity went out. He/She said he/she had not started the morning medication pass yet so all medications were going to be late for the morning pass. He/She said the ADON had spoke with the physician and was told it was okay to pass morning medications late as long as it was not a medication that was duplicated at another medication pass. He/She said he/she would consider medications given late as a medication error.</p> <p>During an interview on 03/06/25 at 7:10 A.M., the Director of Nursing (DON) said he/she had not received education on what to do in the event there was no access to medical records due to electrical outages. He/She said he/she has mentioned the concern to administrative staff before and had not received guidance. He/She said when the electricity went out staff had no access to medical records or MAR's and were not sure of current orders. He/She said he/she considers medications pass late as a medication error, but he/she was not sure what else his/her staff could have done differently in the situation, since there were no procedures in place.</p> <p>During an interview on 03/06/25 at 11:17 A.M., Licensed Practical Nurse (LPN) A said he/she would consider medications given late as a medication error. He/She said he/she was not given education on what to do in the event that they did not have access to medical records or MARs. He/She said in the past the DON/ADON would print current MAR/TARs to have on hand in case there were issues with the weather or electricity. He/She said the facility did not do that anymore.</p> <p>During an interview on 03/06/25 at 11:43 A.M., the ADON said he/she was aware medications were not passed timely. He/She said he/she was the person who called the nurse practitioner about the late meds and was instructed to continue with the morning medications at noon and hold all duplicate medications. He/She said late medications were considered a medication error, but he/she did not have a plan in place for the staff to have access to MARs.</p> <p>During an interview on 03/06/25 at 12:44 P.M., the administrator said staff were not educated and were not aware they should have been printing paper MARs as back up in case they didn't have access to electronic records. He/She said paper MARs should have been printed by the DON. He/She said he/she is not sure if the new DON had been educated on that practice, previously. He/She said medication given outside of time frames are considered medication errors.</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  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Rest Haven Health Care Center		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 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies.</p> <p>43327</p> <p>Based on record review and interview, facility staff did not conduct and document a thorough facility-wide assessment to determine what resources are necessary to care for residents during both day-to-day operations and emergencies. The facility census was 52.</p> <p>1. Review of the facility's Facility Assessment Policy and Tool, dated 06/29/2023, showed:</p> <ul style="list-style-type: none"> <li>-The facility must update the Facility Assessment monthly and as necessary whenever there is, or the facility plans for, any change that would require a substantial modification to any part of the assessment;</li> <li>-The assessment must include the facility resident population, including but not limited to, both the number of and the facilities resident capacity, the care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present in the population, the staff competencies that are necessary to provide the level and types of care needed for the resident population, the physical environment, equipment, services, and other physical plan considerations that are necessary to care for its population, any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including but not limited to, activities, and food and nutrition services;</li> <li>-The facilities resources, including but not limited to, all buildings and/or other physical structures and vehicles, equipment (medical and non-medical), services provided (i.e., physical therapy, pharmacy, specific rehabilitation therapies, psych services, etc), and all personnel, including managers, staff (both, employees, and those who provide services under contract), volunteers, as well as their training and any competencies related to resident care, contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operation and emergencies, health information technology resources, such as systems for electronically managing resident records and electronically sharing information with other organizations, and a facility-based and community-based risk assessment, utilizing an all hazards approach;</li> <li>-The assessment is conducted at the facility level;</li> <li>-The administrator or designated individual assigns a person to lead the Assessment Process;</li> <li>-Individuals involved at a minimum include the Administrator, a member of the governing body, the medical director, and the Director of Nursing (DON);</li> <li>-The facility assessment must be reviewed and updated to address how the facility staff, resources, physical environment, etc., meet the needs of those residents and any areas requiring attention, such as training or supplies to provide care;</li> </ul> <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  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Rest Haven Health Care Center		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 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Consider input from residents, resident representatives, family members, Certified Nurse Aides (CNA)'s, licensed nurses, and Ombudsman about how well current staffing plan has been working and consider when developing the staffing plan.</p> <p>2. Review of the Facility Needs Assessment, dated 03/03/25 showed facility census of 52. Review showed the Facility Needs Assessment did not contain:</p> <p>-Resident capacity, the staff competencies that are necessary to provide the level and types of care needed for the resident population, the physical environment, equipment, services, and other physical plant considerations that are necessary to care for its population, any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including but not limited to, activities, and food and nutrition services;</p> <p>-Facility resources, including but not limited to, all buildings and/or other physical structures and vehicles, equipment (medical and non-medical), services provided and all personnel, including managers, staff (both, employees, and those who provide services under contract), volunteers, as well as their training and any competencies related to resident care, contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operation and emergencies, health information technology resources, such as systems for electronically managing resident records and electronically sharing information with other organizations, and a facility-based and community-based risk assessment, utilizing an all hazards approach.</p> <p>3. During an interview on 03/06/25 at 07:10 A.M., the Director of Nursing (DON) said he/she is interim and hadn't received a any training on the role. He/She said did not know what a facility assessment was and did not have anything to do with it.</p> <p>During an interview on 03/06/25 at 11:29 A.M., the Assistant DON said he/she does not do anything with the facility assessment and did not know what it was.</p> <p>During an interview on 03/06/25 at 12:36 A.M., the Interim Administrator said that the Administrator and DON are responsible for the Facility Assessment and are both new to the facility and role. He/She said that attempts were made to find the one completed prior but was unsuccessful and has not been completed since he/she started.</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  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Rest Haven Health Care Center		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 - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43327</b></p> <p>Based on observation, interview, and record review, facility staff failed to use appropriate infection control procedures to prevent the spread of bacteria or other infectious causing contaminants when facility staff failed change and/or store oxygen and nebulizer tubing in a manner to prevent the spread of bacteria for three residents (Resident #1, #18, and #35) out of three sampled residents. Facility staff failed to maintain proper infection control practices for three residents (Resident # 13, #18 and #25) out of four sampled residents catheters. Facility staff failed to perform appropriate hand hygiene, and glove changes during wound care for one resident (Resident #2) out of two sampled residents. Staff failed to implement the Enhanced Barrier Precautions (EBP) policy when they did not educate, or alert staff of residents who required EBP, and failed to place appropriate personal protective equipment (PPE) in close proximity for four (Resident #1, #2, #25, #40) of six sampled residents. Facility staff failed to appropriately sanitize a multi-use glucometer (a device for monitoring blood sugars) after use for two residents (Resident #16, and #34) out of 4 sampled residents, to prevent the spread of infection causing contaminants. Facility staff failed to ensure the two-step purified protein derivative (PPD) (skin test for Tuberculosis (TB)) completed for five residents (Resident #13, #18, #20, #45, and #52) out of six sampled residents. Facility staff failed to handle soiled linens in a manner to prevent the spread of infection causing contaminants for one resident (Resident #33) of two sampled residents. The facility's census was 52.</p> <p>1. Review of the facility's Oxygen Administration policy, dated 05/18/24, showed manufacturer recommendations for the frequency of cleaning equipment filters:</p> <ul style="list-style-type: none"> <li>-Change oxygen tubing and mask/cannula weekly and as needed if becomes soiled or contaminated;</li> <li>-Change humidity bottle when empty, every 72 hours or per facility policy, or as recommended by the manufacturer;</li> <li>-Change nebulizer tubing and delivery devices every 72 hours or per facility policy and as needed if they become soiled or contaminated;</li> <li>-Keep delivery devices covered in plastic when not in use.</li> </ul> <p>Review of the facility's Administration of Nebulizer Therapy policy, dated 05/14/24, showed staff are directed to disassemble and rinse the nebulizer with sterile or distilled water and allow to air dry on an absorbent towel after each use. Once completely dry, staff are to store the nebulizer cup and mouthpiece in a zip lock bag and change the tubing every seventy-two hours or per facility policy.</p> <p>2. Review of Resident #1's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 01/31/25, showed staff assessed the resident as:</p> <ul style="list-style-type: none"> <li>-Cognitively impaired;</li> <li>-Required oxygen;</li> </ul> <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  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Rest Haven Health Care Center		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 - Many</p>	<p>-Diagnosis of heart failure.</p> <p>Observation on 03/05/25 at 12:37 P.M., showed the resident with oxygen on via nasal cannula at two liters per minute. The oxygen concentrator did not contain filters. There was visible white/tan debris covering the filter location.</p> <p>3. Review of Resident #18's Quarterly MDS, dated [DATE], showed staff assessed the resident as:</p> <p>-Cognitively intact;</p> <p>-Did not use oxygen;</p> <p>-On hospice;</p> <p>-Diagnosis of heart failure, pneumonia, and lung disease.</p> <p>Observation on 03/03/25 at 10:46 A.M., showed the resident in bed with oxygen on via nasal cannula to the oxygen concentrator. The oxygen concentrator contained white debris build-up on both filters and the oxygen tube undated. Observation showed a nebulizer machine on the nightstand with the mouthpiece and nebulizer cup on top of the machine and not bagged or dated.</p> <p>4. Review of Resident #35's quarterly MDS, dated [DATE], showed staff assessed the resident as follows:</p> <p>-Severe cognitive impairment;</p> <p>-Diagnosis of Alzheimer's and dementia.</p> <p>Observation on 03/03/25 at 10:57 A.M., showed the resident's nebulizer mask on the bedside table and not bagged.</p> <p>Observation on 03/04/25 at 03:00 P.M., showed the resident's nebulizer mask on the bedside table and not bagged.</p> <p>5. During an interview on 03/06/25 at 07:10 A.M., the Director of Nursing (DON) said it is the responsibility of the nursing staff to change the filters on the concentrators. He/She said they change oxygen tubing weekly, but the filters only need to be changed periodically. He/She said the masks/nasal cannulas need to be stored in bags when not in use. The DON said they should not be left on bedside tables or on the floor.</p> <p>During an interview on 03/06/25 at 11:17 A.M., Licensed Practical Nurse (LPN) A said it is the responsibility of the nurses to change out the oxygen and nebulizer tubing, masks, and filters. He/She said it is done weekly on either Saturday or Sunday. He/She said the Assistant Director of Nursing (ADON) would be responsible for ensuring they are getting them done. He/She said it is important they are getting changed and placed in a bag when not used, to prevent infections.</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  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Rest Haven Health Care Center		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 - Many</p>	<p>During an interview on 03/06/25 at 11:43 A.M., the ADON said it is the responsibility of the nurses to ensure oxygen and nebulized masks, tubing and filters are changed. He/She said they usually change their tubing on Sundays and filters should also be changed on those days. He/She said staff are expected to place masks, tubing and nebulizer parts in a ziplocked bag when not in use. He/She was not aware there were dirty filters and masks/nebulizers not placed in zip lock bags.</p> <p>During an interview on 03/06/25 at 12:44 P.M., the administrator said ultimately it is the responsibility of the DON to ensure nursing staff are changing masks, tubing and filters and ensuring they are placed in zip lock bags when not used. He/She said it is the nurses who have the orders to change them out weekly and who should be placing them in the zip lock bags. He/She said he/she was not aware there were filters covered in debris and not placed in bags.</p> <p>6. Review of the facility's Catheter Care policy, dated 06/26/24, showed the policy did not contain direction or guidance to keep the catheter drainage bag or tubing off the floor.</p> <p>7. Review of Resident #13's Quarterly MDS, dated [DATE], showed staff assessed the resident as:</p> <ul style="list-style-type: none"> <li>-Cognitively impaired;</li> <li>-Dependent on staff for toileting needs;</li> <li>-Had an indwelling catheter.</li> </ul> <p>Observation on 03/03/25 at 11:03 A.M., showed the resident sat in his/her room in a wheelchair and his/her catheter drainage bag hung from the bottom of the wheelchair. The bottom of the drainage bag touched the floor.</p> <p>8. Review of Resident #18's Quarterly MDS, dated [DATE], showed staff assessed the resident as:</p> <ul style="list-style-type: none"> <li>-Cognitively intact;</li> <li>-Indwelling catheter;</li> <li>-On hospice;</li> <li>-Dependent on staff for toileting.</li> </ul> <p>Observation on 03/04/25 at 8:09 A.M., showed the resident at the nurse station in his/her wheelchair with his/her catheter drainage bag attached to the bottom of the wheelchair. The drainage bag tubing and bag touched the floor.</p> <p>Observation on 03/05/25 at 8:27 A.M, showed the resident at the nurse station in his/her wheelchair with his/her catheter drainage bag attached to the bottom of the wheelchair. The drainage tubing touched the floor.</p> <p>9. Review of Resident #25's Annual MDS, dated [DATE], showed staff assessed the resident as follows:</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  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Rest Haven Health Care Center		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 - Many</p>	<p>-Severe cognitive impairment;</p> <p>-Indwelling catheter;</p> <p>-Diagnosis of neurogenic bladder, quadriplegia, and cerebral palsy.</p> <p>Observation on 03/03/25 at 11:16 A.M., showed the resident's catheter bag on the floor of his/her room.</p> <p>Observation on 03/03/25 at 3:40 P.M., showed the resident's catheter bag on the floor of his/her room.</p> <p>10. During an interview on 03/06/25 at 7:10 A.M., the DON said catheters should be kept below the level of the bladder and never on the floor. He/She said there is a risk for infection if not done properly.</p> <p>During an interview on 03/06/25 at 9:55 A.M., Certified Medication Technician (CMT) B said catheters should be placed below the waist and never on the floor. He/She said catheter bags should never be placed on the floor to prevent cross contamination.</p> <p>During an interview on 03/06/25 at 11:17 A.M., LPN A said catheters should be kept below the abdomen and secured at the thigh. He/She said they should never touch the floor or placed above the abdomen, to prevent infection.</p> <p>During an interview on 03/06/25 at 12:44 P.M., the administrator said it is his/her expectation catheter bags are hooked to the bed or chairs and staff ensure they are below the waist and draining properly. He/She said catheter bags should never be on the floor or touching the floor to prevent cross contamination.</p> <p>11. Review of the Facility's Clean Wound Dressing Change policy, revised 05/18/24, showed:</p> <p>-It is the policy of this facility to provide wound care in a manner to decrease potential for infection and/or cross-contamination;</p> <p>-Each wound will be treated individually;</p> <p>-When multiple wounds are being dressed, the dressings will be changed in order of least contaminated to most contaminated (i.e. change extremity wounds before wounds contaminated with stool). Dressings of infected wounds should be changed last.</p> <p>10. Review of resident #2's PPS 5-day Assessment MDS, dated [DATE], showed staff assessed the resident as follows:</p> <p>-Cognitively intact;</p> <p>-Two unstageable pressure ulcers with suspected deep tissue injury in evolution;</p> <p>-Diagnosis of Cancer.</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  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Rest Haven Health Care Center		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 - Many</p>	<p>Review of the Physician Order Sheet (POS), dated 01/28/25, showed an order to cleanse heel and toe with wound cleaner, apply xeroform, and apply border gauze one time a day.</p> <p>Observation on 03/05/25 at 9:45 A.M., showed the LPN A entered the resident's room to provide wound care. The LPN cleansed the open toe wound on the residents left foot, with the same soiled gloves the LPN, cleansed an open wound on the side of the residents left heel, cut the xeroform to size, and labeled the bandages.</p> <p>During an interview on 03/06/25 at 7:10 A.M., the DON said he/she expects his/her staff to wash hands or sanitize between glove changes, before touching clean supplies, and when moving between clean and dirty tasks. He/She said he/she should clean one wound and change gloves and perform hand hygiene before moving to another wound to prevent cross contamination.</p> <p>During an interview on 03/06/25 at 11:17 A.M., LPN A said it is important to wash or sanitize hands when you change gloves, go between clean and dirty tasks, touch clean supplies and when you go from one wound to the other. He/She said it is important to perform hand hygiene practices, so infections are not spread to other wounds. He/She said he/she forgot to change gloves and perform hand hygiene between wounds and before touching clean supplies because he/she was nervous.</p> <p>During an interview on 03/06/25 at 12:44 P.M., the administrator said it is his/her expectation staff perform hand hygiene and glove changes in-between wounds to prevent the spread of infections. He/She would expect staff to change gloves and perform hand hygiene before touching clean supplies and treat each wound separately. He/she said it is the responsibility of the DON to over see wounds and that the nursing staff is performing them properly.</p> <p>12. Review of the Facility's Enhanced Barrier Precautions (EBP) policy, not dated, showed:</p> <p>-An order for EBP will be obtained for residents with any of the following:</p> <p>--Wounds (e.g., chronic wounds such as a pressure ulcer, diabetic foot ulcers, unhealed surgical; wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, Medline catheters) even if the resident is not known to be infected or colonized with a MDRO;</p> <p>-The facility will ensure gowns and gloves are available immediately near or outside of the resident's room.</p> <p>13. Review of Resident #1's Quarterly MDS, dated [DATE] showed staff assessed the resident as:</p> <p>-Rarely or never understood;</p> <p>-Had a feeding tube (tube placed into the stomach to administer artificial nutrition and fluids);</p> <p>-Received greater than 51 percent of nutrition and fluids through a tube;</p> <p>-Diagnosis of Cerebral Palsy.</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  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Rest Haven Health Care Center		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 - Many</p>	<p>Observation on 03/04/25 12:01 P.M., showed an EBP sign hung from the residents door and PPE not in close proximity to the resident's room. Observation showed LPN A administered artificial nutrition and hydration by feeding tube to the resident and the LPN did not have a gown on.</p> <p>Observation on 03/05/25 at 12:37 P.M., showed LPN A administered artificial nutrition and hydration by feeding tube and the LPN did not have a gown on.</p> <p>14. Review of Resident #2's PPS 5-day Assessment MDS, dated [DATE], showed staff assessed the resident as follows:</p> <ul style="list-style-type: none"> <li>-Cognitively intact;</li> <li>-Two unstageable pressure ulcers with suspected deep tissue injury in evolution;</li> <li>-Diagnosis of Cancer.</li> </ul> <p>Observation on 03/05/25 at 9:45 A.M., showed the resident's room did not contain a sign to alert staff on the use of EBP and PPE not in close proximity. Observation showed LPN A performed wound care and did not wear a gown.</p> <p>15. Review of Resident #25's Annual MDS, dated [DATE], showed staff assessed the resident as:</p> <ul style="list-style-type: none"> <li>-Cognitively impaired;</li> <li>-Had a feeding tube and indwelling catheter;</li> <li>-Received greater than 51 percent of nutrition and fluids through a tube;</li> <li>-Diagnosis of Cerebral Palsy, quadriplegia, and neurogenic bladder (muscles and nerves that control bladder are no longer working).</li> </ul> <p>Observation on 03/04/25 11:48 A.M., showed an EBP sign hung from the residents door and PPE not in close proximity to the resident's room. Observation showed LPN A administered artificial nutrition and hydration by feeding tube to the resident and the LPN did not have a gown on.</p> <p>Observation on 03/05/25 at 12:00 P.M., showed LPN A and Certified Nurse Aide (CNA) J provided catheter and perineal care to the resident. LPN A and CNA J did not wear a gown.</p> <p>Observation on 03/05/25 at 12:16 P.M., showed LPN A administered artificial nutrition and hydration to the resident by feeding tube and did not wear a gown.</p> <p>16. Review of Resident #40's Annual MDS, dated [DATE] showed staff assessed the resident as:</p> <ul style="list-style-type: none"> <li>-Cognitively impaired.</li> <li>-Diagnosis of stroke.</li> </ul> <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  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Rest Haven Health Care Center		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 - Many</p>	<p>Observation on 03/03/25 at 3:10 P.M., showed CMT M and CNA N entered the room to transfer the resident using a mechanical lift from the wheelchair to the bed. The resident had an IV placed in her left arm. Once in bed, CMT M and CNA N provided perineal care. CMT M and CNA N did not wear a gown.</p> <p>17. During an interview on 03/06/25 at 07:10 A.M., the DON said the ADON would be responsible for EBP, but is new and probably doesn't know. He/She said he/she knows there should be a sign on the residents door that alerts them a resident is on EBP and they should have PPE available. He/She said anyone with open wounds, catheters, tube feedings, or IVs should be on precautions. He/She said it is important to prevent infections in at risk residents.</p> <p>During an interview on 03/06/25 at 9:55 A.M., CMT/CNA B said he/she knows residents on EBP should have signs on the doors, PPE boxes available outside their door, and a biohazard box to dispose of the gowns. He/She said residents who are tube fed, have catheters, wounds, IVs, and infections should be on EBP. He/She said he/she knows they have the EBP signs, PPE boxes, and biohazard boxes available, staff are just not using them. He/She said they do not have an infection preventionist at this time and believes that is why EBPs have not been used.</p> <p>During an interview on 03/06/25 at 11:43 A.M., the ADON said residents who have Methicillin-resistant Staphylococcus aureus (MRSA), feeding tubes, IVs, wounds, and catheters should all have EBP. He/She said residents on EBP should have a sign on their door alerting staff. He/She said they keep their PPE in the storage room and staff can get it there before going into a room. He/She said staff should place PPE in a trash bag, when done, and then place the trash bag in the biohazard bag in the dirty utility room. He/She said it is the responsibility of the nurses to put up the EBP signs. He/She said staff should wear gowns and gloves when performing catheter care, wound care, and tube feedings.</p> <p>During an interview on 03/06/25 at 12:44 P.M., the administrator said he/she expects staff to have the proper equipment available for residents on EBP. He/She said signs should be placed on the door, PPE available at their door, and biohazard boxes should be placed in their rooms. He/She said it is the responsibility of the DON to place EBP signs and equipment. He/She said residents who have catheters, are tube fed, have infections conditions, IVs, and wounds should all be on EBP. He/She said he/she became aware that staff were not performing EBP throughout the week as he/she has observed staff. He/She said he/she is not sure if staff have been educated one EBP, but it is his/her expectation that the DON is responsible for the process and ensuring education was done.</p> <p>18. Review of the Facility's Glucometer Disinfection Policy, revised 04/30/24, showed:</p> <ul style="list-style-type: none"> <li>-The facility will ensure blood glucometers will be cleaned and disinfected after each use and according to the manufacturer's instructions for multi-resident use;</li> <li>-The glucometers will be disinfected with a wipe pre-saturated with EPA registered healthcare disinfectant that is effective against HIV, Hepatitis C and Hepatitis B virus;</li> <li>-Procedure:</li> <li>-Using first wipe, clean first to remove heavy soil, blood and/or other contaminants left on the surface of the glucometer;</li> </ul> <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  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Rest Haven Health Care Center		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 - Many</p>	<p>-After cleaning, use second wipe to disinfect the glucometer thoroughly with the disinfectant wipe, following manufacturer's instructions. Allow glucometer to air dry.</p> <p>19. Review of resident #16's Quarterly MDS, dated [DATE], showed staff assessed the resident as follows:</p> <p>-Cognitively intact;</p> <p>-Received insulin injections seven of seven days;</p> <p>-Diagnosis of Diabetes mellitus.</p> <p>Observation on 03/05/25 at 11:34 A.M., showed LPN A removed a glucometer from the top of the medication cart, donned gloves, checked the resident's glucose level. He/She removed his/her gloves and returned to the medication cart. He/She did not sanitize the multi-use glucometer after use or before checking the next residents blood glucose level.</p> <p>19. Review of Resident #34's Quarterly MDS, dated [DATE], showed staff assessed the resident as follows:</p> <p>-Cognitively intact;</p> <p>-Received insulin injections seven of seven days;</p> <p>-Diagnosis of Diabetes mellitus.</p> <p>Observation on 03/05/25 at 11:53 A.M., showed LPN A removed a glucometer from the top of the medication cart, donned gloves, checked the resident's glucose level. He/She then removed his/her gloves and returned to the medication cart. He/She did not sanitize the multi-use glucometer after use or before placing the glucometer in the top drawer of the medication cart.</p> <p>20. During an interview on 03/06/25 at 7:10 A.M., the DON said staff should be using two glucometers when performing blood sugars. The DON said one should be drying while the other is in use. He/She said all staff who perform blood sugars on residents should be educated on glucometer sanitizing and disinfecting glucometers. He/She said you should use one wipe to clean the glucometer and then a second to wrap it and let it sit for five minutes. He/She said you should never use the same glucometer without disinfecting it and you should not place it in the medication cart without sanitizing it to prevent cross contamination.</p> <p>During an interview on 03/06/25 at 11:17 A.M., LPN A said glucometers should be sanitized and disinfected before they are used, before they are put in the cart, and after each use on a resident. He/She said he/she missed disinfecting the glucometers in-between two residents and before he/she put the glucometer away because he/she was nervous.</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  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Rest Haven Health Care Center		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 - Many</p>	<p>During an interview on 03/06/25 at 12:44 P.M., the administrator said some of the CMT staff have been certified to do insulin and perform blood sugar tests. He/She said he/she expects CMTs and nurses to disinfect glucometers before starting blood sugars, in-between residents and before placing them back into the medication cart. He/She said it is important to disinfect the glucometers to prevent cross contamination. He/She said he/she is not sure if staff get on going education on glucometers use and cleaning, but he/she said it should be common practice to disinfect the glucometers.</p> <p>21. Review of the Facility's Tuberculosis Testing policy, revised 06/29/23, showed upon admission and readmission, each resident will receive a 2 step Purified Protein derivative (PPD) skin test as ordered by the physician.</p> <p>22. Review of Resident #13's electronic medical record (EMAR), showed the resident admitted to the facility on [DATE]. Review showed the medical record record did not contain a completed two-step PPD.</p> <p>23. Review of Resident #18's EMAR, showed the resident admitted to the facility on [DATE]. Review showed the medical record record did not contain a completed two-step PPD.</p> <p>24. Review of Resident #20's EMAR, showed the resident admitted to the facility on [DATE]. Review showed the medical record record did not contain a completed two-step PPD.</p> <p>25. Review of Resident #45's EMAR, showed the resident admitted to the facility on [DATE]. Review showed the medical record record did not contain a completed two-step PPD.</p> <p>Review of the resident's POS, showed the resident admitted to the facility on [DATE]. Review showed the medical record record did not contain a completed two-step PPD.</p> <p>26. Review of Resident #52's EMAR, showed the resident admitted to the facility on [DATE]. Review showed the medical record record did not contain a completed two-step PPD.</p> <p>27. During an interview on 03/05/25 at 11:47 A.M., the ADON said they do not have documentation of these resident's two-step PPD. He/She does not know if they were completed.</p> <p>28. During an interview on 03/06/25 at 7:10 A.M., the DON said the policy is for a two-step PPD to be done on admission.</p> <p>During an interview on 03/06/25 at 12:44 P.M., the administrator said all residents should receive a two-step PPD upon admission and receive annual screenings. He/She said it is the responsibility of the DON to ensure the resident TBs are completed. He/She said he/she does not know why they were not done and said prior to survey he/she was not aware they were not getting done.</p> <p>29. Review of the facility's Handling Clean and Dirty Linen policy, dated 06/26/24, showed:</p> <p>-Linen should not be allowed to touch the floor;</p> <p>-Used or soiled linen shall be collected at the bedside a placed in a linen bag or designated lined receptacle. When the task is completed, the bag will be closed securely and placed in the soiled utility room.</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  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Rest Haven Health Care Center		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 - Many</p>	<p>28. Review of Resident #33's Quarterly MDS, dated [DATE] showed staff assessed the resident as:</p> <ul style="list-style-type: none"> <li>-Cognitively impaired.</li> <li>-Incontinent of bowel and bladder;</li> <li>-Required partial to moderate assistance for toilet hygiene;</li> <li>-Diagnosis of stroke.</li> </ul> <p>Observation on 03/06/25 at 4:52 A.M., showed CNA L and NA D entered the room to provide incontinence care to the resident who remained in bed. CNA L removed the visibly wet sheets from the bed and placed them on the floor. NA D applied a clean sheet to the mattress. CNA L and NA D did not wipe off the wet mattress before they applied the dry clean sheet.</p> <p>During an interview on 03/06/25 at 05:03 A.M., CNA L said he/she was just trying to get everything done since there are only two aides in the building. He/She said normally he/she would have set the linens on the chair instead of the floor but was just so busy trying to get everyone clean and dry. He/She said he/she didn't think about cleaning off the mattress before applying a new sheet but said it makes sense so the urine is not on the residents skin. CNA L said he/she is self taught and has not completed all the computer training yet.</p> <p>During an interview on 03/06/25 at 07:10 A.M., the DON said staff should bag soiled linens and place directly into a bag at the foot of the bed and not on the floor. Placing the soiled linens on the floor could cause infection control issues due to the dirt on the floor.</p> <p>During an interview on 03/06/25 at 11:17 A.M., LPN A said dirty linens should be placed in a trash bag after removal and should never be placed on the floor or against their body.</p> <p>During an interview on 03/06/25 at 12:36 P.M., the Administrator said he/she would expect staff to bag soiled linen and take them directly to the linen room. Soiled linens should not be placed on the floor to prevent cross contamination (spread of bacteria).</p> <p>47193</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  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Rest Haven Health Care Center		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 0881</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Implement a program that monitors antibiotic use.</p> <p>47193</p> <p>Based on interview and record review, facility staff failed to implement an Antibiotic Stewardship Program with antibiotic use protocols and a system to monitor and track antibiotic use within the facility. The facility census was 52.</p> <p>1. Review of the facility's Antibiotic Stewardship Program policy, revised 06/29/23, showed to optimize antibiotic use in our home and reduce unnecessary use of laboratory tests and antibiotics using a systematic approach:</p> <ul style="list-style-type: none"> <li>-The Antibiotic Stewardship Program (ASP) will comply with state and federal laws and regulations;</li> <li>-The ASP will be run by the facility Antibiotic Steward, who will lead the Antibiotic Stewardship Team (AST). At a minimum, the AST will be comprised of the Director of Nursing (DON), a nurse with administrative duties, and a charge nurse;</li> <li>-The facility ASP will use a systematic evaluation of ongoing treatment,</li> <li>-The facility will track and monitor antibiotic prescribing practices and resistance patterns among its residents;</li> <li>-The facility Antibiotic Steward will review and generate the Infection Log in the Point Click Care (PCC);</li> <li>-At the end of each month, the Facility Antibiotic Steward will print the Monthly Infection Log. This report will be placed in the ASP binder and the weekly reports from that month will be removed.</li> </ul> <p>2. Review of the facility's antibiotic stewardship program did not contain documentation staff tracked antibiotic trends.</p> <p>During an interview on 03/05/25 at 2:43 P.M., the Chief Nursing Director said they do not currently have an infection preventionist (IP) and do not have anyone to track, trend or implement an ASP. His/Her expectations are the Infection Preventionist would keep track of antibiotics use through out the month and then find trends in antibiotic use.</p> <p>During an interview on 03/06/25 at 11:43 A.M., the Assistant Director of Nursing (ADON) said they do not have anyone implementing the ASP. He/She said he/she was not aware it wasn't getting done.</p> <p>During an interview on 03/06/25 at 12:44 P.M., the interim administrator said he/she was not aware the facility did not have anyone tracking and trending antibiotic use. He/She said the facility does not currently have and ASP.</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  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Rest Haven Health Care Center		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 0882</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.</p> <p>47193</p> <p>Based on interview and record review, the facility staff failed to designate one or more individuals with specialized training in Infection Prevention and Control (IPC) as the Infection Preventionist (IP) for the facility's infection prevention and control program. The census was 52.</p> <p>1. Review of the facility's Infection Preventionist Policy, revised 03/05/2025, showed the facility will employ one or more qualified individuals with responsibility for implementing the facility's infection prevention and control program.</p> <p>2. During an interview on 03/05/25 at 2:43 P.M., the Chief Nursing Director said they do not currently have an infection preventionist (IP). He/She said the Assistant Director of Nursing (ADON) is working on getting certified.</p> <p>During an interview on 03/06/25 at 7:10 A.M., the Director of Nursing (DON) said they do not currently have an IP. He/She said he/she is not sure who is monitoring, tracking, educating facility staff members on infection control. He/She just recently became the DON. He/She said he/she usually works the floor as the charge nurse.</p> <p>During an interview on 03/06/25 at 11:43 A.M., the ADON said they do not have an IP. He/She said the facility recently asked him/her to get certified to become the IP, but he/she is not sure how he/she will find the time to get certified. He/She has not started the certification yet. He/She said he/she was not sure how much time needed to be dedicated to the IP position, but he/she is already running thin on free time.</p> <p>During an interview on 03/06/25 at 12:44 P.M., the interim Administrator said he/she was not aware the facility did not have an IP.</p>		