STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265182	A. Building B. Wing	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ascend at Aurora	1700 South Hudson Avenue Aurora, MO 65605

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received care consistent with professional standards of practice to promote prevention and healing of pressure ulcers (refers to localized damage to the skin and/or underlying tissue usually over a bony prominence) pressure ulcers when the facility failed to timely assess, document, and implement treatment and monitoring of a pressure ulcer for two resident (Resident #3 and #4). The facility census was 53.Review of the facility policy titled Skin Integrity- Pressure and Non-Pressure reviewed 06/30/25, showed the following information:-Pressure and other ulcers will be assessed and measured at least weekly by a licensed nurse and documented;-A skin condition assessment and pressure ulcer risk assessment will be completed at the time of admission. The pressure ulcer risk assessment will be updated quarterly and as necessary;-Residents identified will have a weekly skin assessment by a licensed nurse. A wound assessment will be initiated and documented in the resident chart when pressure skin conditions are identified;-Each resident will be observed for skin breakdown daily during care and on the assigned bath day by the Certified Nursing Assistant (CNA). Changes shall be reported to the charge nurse who will perform the detailed assessment. At the earliest sign of a pressure ulcer or other skin problems, the resident, legal representative, and the attending physician will be notified;-The initial observation of the ulcer or breakdown will also be described in the nursing progress notes and/or risk assessment.1. Review of Resident #3's face sheet (brief look at resident information) showed the following information:-admission date of 02/26/26;-Diagnoses include compression fracture of the lumbar vertebra (lower back), high blood pressure, and fibromyalgia (a chronic disorder characterized by widespread musculoskeletal pain, fatigue, sleep disturbances, and brain fog).Review of the resident's comprehensive Minimum Data Set (MDS- a federally mandated assessment tool filled out by facility staff), dated 02/26/26, showed the following information:-Intact cognition;-The resident had a stage three (full-thickness loss of skin) pressure ulcer and at risk for developing pressure ulcers;-Required pressure reducing device for chair and bed;-Required pressure ulcer care.Review of the resident's care plan, dated 02/26/26, showed staff did not care plan related to the identified stage III pressure ulcer. Review of the resident's Nursing Admission/readmission Data Collection Assessment, dated 02/27/26, showed the following information:-Moderate risk for impaired skin integrity;-Did not have impaired skin integrity;-No open areas.Review of the resident's Post Acute Care Handoff document from his/her hospital stay, dated 02/22/26, showed the resident had a pressure ulcer to his/her midline sacral spine (the central ridge on the posterior aspect of the inverted triangle shaped sacrum).Review of the resident's medical record showed facility staff did not document completion of a skin assessment had been documented on admission.Review of the resident's progress note dated 03/06/26, at 3:22 P.M., showed the following information:-The resident had excoriation to his/her buttocks;-The progress note did not document any measurements, description, or physician and family notifications.Review of the resident's shower sheet, dated 03/06/26, showed no new skin issues were documented.Review of the resident's progress note dated 03/07/26, at 4:35 P.M., showed the following information:-The resident had excoriation to his/her buttocks;-The progress note did not document any measurements, (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	description, or physician and family notifications.Review of the resident's progress note dated 03/09/26, at 3:21 P.M., showed a wound assessment completed and referred to the assessment for further information.Review of the resident's wound assessment dated [DATE], at 3:01 PM., showed the following:-A facility acquired stage III pressure ulcer had been identified on the resident's coccyx (a small triangular bone located at the very bottom of the spine, also known as the tailbone);-The family and physician were notified;-The wound was 50 percent slough (non-viable yellow, tan, gray, green or brown tissue) and was draining serosanguinous (a thin, watery, pale red or pink fluid) drainage;-The wound measured 1.3 centimeters (cm) by 1.4 cm by 0.8 cm;-Staff noted care plan reviewed and updated.(This was the first document wound assessment after admission.)Review of the resident's care plan showed staff did not update the care plan to reflect the identified stage III pressure ulcer. Review of the resident's March 2026 Physician Order Sheet (POS) showed the following:-An order, dated 03/09/26, for skin assessments to be completed every Monday as part of the admission protocol;-An order, dated 03/09/26, for a low air loss mattress due to stage III wound;-An order, dated 03/12/26, to clean stage III coccyx with wound cleanser, apply calcium alginate (highly absorbent material commonly used for heavily exudating (draining) wounds), cover with super absorbent silicone border foam dressing, and change daily until resolved.Review of the resident's March 2026 Treatment Administration Record (TAR) showed the facility-initiated treatment to the wound on 03/12/26.Review of the resident's progress note dated 03/15/26, at 6:26 P.M., showed the resident's coccyx stage III wound had a moderate amount of purulent (pus filled) drainage noted with an odor. Staff notified the physician. (This was the first documentation regarding the wound after 03/09/26.) Review of the resident's skin assessment, dated 03/17/26, showed the following information:-Stage III pressure ulcer to the resident's coccyx measuring 3.1 cm by 2.5 cm by 0.6 cm with 1.0 cm of redness around the wound. The wound bed consisted of 90 % slough, 10 % of pale pink tissue, and had a scant amount of yellow drainage;-New orders were obtained to apply Santyl (a prescription topical medication used to remove dead tissue (debridement) from chronic skin ulcers) to the wound bed;-Care plan reviewed and updated.Review of the resident's March 2026 POS showed an order, dated to begin on 03/17/26, for Santyl, apply to coccyx topically everyday shift for wound care until resolved.Review of the resident's care plan, dated 03/17/26, showed the following:-The resident had potential/actual impairment to his/her skin integrity related to a coccyx wound;-Administer medications as ordered and monitor and document for side effects;-Administer treatments as ordered and monitor for effectiveness;-Avoid sheering while repositioning in bed;-Low air-loss mattress to bed for pressure reduction relief;-Monitor pressure areas for changes in color, sensation, and temperature. Report changes to the physician;-Monitor/document/report signs and symptoms of infection to the physician.Observation on 03/17/26, at 3:00 P.M., showed a slough covered wound a little larger than quarter sized to the resident's coccyx. The peri-wound (surrounding skin) was pale pink. During an interview on 03/17/26, at 2:06 P.M., CNA A said the following:-He/she noticed the resident's wound around 03/09/26 while providing incontinent care and reported it to the Administrator. The wound was on the resident's coccyx and was slough covered and had some green appearing drainage. The physician happened to be present that day and ordered treatment.During an interview on 03/18/26, at 10:39 P.M., Licensed Practical Nurse (LPN) C said the following:-He/she looked through the resident's medical record and noted that the resident did not have a skin assessment on admission or routine weekly skin assessments completed.;-Whoever had put in the resident's admission orders did not include weekly skin assessments, so that was not triggering for nurses to complete;-He/she believed the wound was present on admission, but since a skin assessment was not completed that cannot be proved.During an interview on 03/18/26, at 1:48 P.M., the Administrator said the following:-She became aware of the wound around the week of 03/09/26;-When she observed the wound, it was slough covered and nurses were expected to implement interventions such as a low air loss mattress and contact the physician for treatment orders.2. Review of Resident #4's face sheet showed the following information:-re-admission date of (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	02/15/26;-Diagnoses included pneumonia, chronic obstructive pulmonary disease (COPD - progressive lung disease that restricts air flow and causes breathing difficulties), and disorder of kidney and ureters (urinary tract).Review of the resident's care plan, dated 12/22/25, showed staff did not care plan related to a risk for skin breakdown and/or if the resident had skin breakdown.Review of the resident's admission (MDS, dated [DATE], showed the following information:-Severe cognitive impairment;-At risk for developing pressure ulcers;-No pressure ulcers or skin concerns-Required pressure reducing device for chair and bed;-Does not require turning and repositioning program.Review of the resident's February 2025 POS showed an order, dated 02/02/26, to apply barrier cream to coccyx (a small triangular bone at the base of the spine)/peri-area every shift for prevention.Review of the resident's Nursing Admission/readmission Data Collection Assessment, dated 02/15/26, showed staff noted no impaired skin integrity.Review of the resident's bath assessment, dated 02/16/26, showed the resident had bumps on his/her bottom. The charge nurse did not sign the form.Review of the resident's medical record showed the resident was sent to the hospital on [DATE] for altered mental status.Review of the resident's progress note dated 02/21/26, at 2:32 P.M., showed he resident's family member had been called for an update regarding the hospitalized resident. The resident's family member stated the hospital staff found two bed sores on the resident's backside that have a current MRSA (Methicillin-resistant Staphylococcus aureus- an infection caused by a type of staph bacteria that has become resistant to many antibiotics) infection.Review of the resident's progress note dated 02/28/26, at 3:28 P.M., showed the following information:-The resident had returned from the hospital with a diagnoses of pneumonia and Covid;-The resident had shearing to the bilateral (both) buttocks with blanchable erythema (red inflamed area that turns white(blanches) when pressed and then returns to red indicated intact capillaries and temporary inflammation) surrounding.(Staff did not document an assessment of the wounds, new orders for the wounds, or notifications to the resident's physician or family.)Review of the resident's medical record showed staff did not complete a skin assessment completed on 02/28/26 through 03/05/26, when the resident was transferred to the hospital again.Review of the resident's progress notes, dated 02/28/26 through 03/05/26, showed staff did not document regarding the resident's wounds or physician notifications.Review of the resident's physician orders, dated 02/28/26 through 03/05/26, showed staff document new wound care orders or interventions.Review of the resident's care plan, dated 12/22/25, showed staff did not update the resident's care plan related to a risk for skin breakdown and/or if the resident had skin breakdown.During an interview on 03/18/26, at 10:07 A.M., Certified Medication Technician (CMT) B said the resident had wounds on his/her bottom up to maybe two months ago. He/she believed the staff were putting ointment on them.3. During an interview on 03/17/26, at 2:06 P.M., CNA A said the following:-He/she was not aware of nurses completing wound monitoring rounds since the new Director of Nursing (DON) was hired;-He/she did not believe nurses were completing their skin assessments timely;-On occasion nurses would ask him/her to assist with rolling the resident's while they provide wound care, but he/she had not seen a nurse measure wounds.During an interview on 03/18/26, at 10:07 A.M., CMT B said the following:-If he/she were to see a new or worsening open area on the resident's skin, he/she would report it to the charge nurse, who should perform an assessment, document, and make necessary notifications to the physician and family. During an interview on 03/18/26, at 10:39 P.M., LPN C said the following:-If he/she were notified by CNAs a new open area on the skin were present, he/she would go and assess and measure the wound. After assessing the wound, he/she would contact the resident's physician and family. The physician would give treatment orders. The nurses should document the wound findings and the new orders;-Skin assessments should be completed weekly and wounds should be assessed and measured every week;-He/she was not aware of anyone completing weekly wound rounds.During an interview on 03/18/26, at 12:08 P.M., the Director of Nursing (DON) said the following:-Skin assessments were expected to be completed on admission and weekly thereafter;-There used to be an Assistant Director (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of Nursing (ADON) who was responsible for doing wound and skin assessments, however that is now the charge nurses responsibility;-She was not sure how the nurses know when to complete skin assessments. She was told by the nurses that it just populates on the resident's assessments in the medical record, but she was unsure;-She did not know the current computer system and was getting training on it;-She believed the charge nurses completed skin assessments, but she has not completed audits on that yet, the ADON use to;-After the ADON left, the weekly wound monitoring and measuring became her responsibility and she did not get them done until the end of the week as she was not aware of all the steps that went into that;-Skin and wound assessments should be completed and documented on weekly;-If a new open area were brought to the charge nurse's attention, she expected them to assess, measure, document, notify the physician and family, obtain treatment orders, and document any prevention interventions.During an interview on 03/18/26, at 1:35 P.M., the MDS Coordinator said the following:-Wound treatment and management should be care planned;-Aside from her, nurses and management have the ability to update the care plan.During an interview on 03/18/26, at 1:48 P.M., the Administrator said the following:-She expected nurses to assess newly reported open areas on the skin. The nurse should measure the wound and reach out to the physician to obtain treatment orders. This should be done immediately, not days after finding the new area;-She expected skin and wound assessments to be completed and documented weekly;-Prevention measures should be documented and care planned.#2803841

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, interview, and record review the facility failed to ensure residents received and the facility provided food to accommodate resident allergies when the facility failed to ensure residents were not served foods they were allergic to, failed to care plan resident allergies, and failed to enter resident allergies into the physician orders for one resident (Resident #1) out of 6 sampled residents. The facility census was 53.Review of the facility policy titled Food Allergies and Intolerances, reviewed on 10/01/25, showed the following information:-Residents are assessed for history of food allergies upon admission as part of the comprehensive assessment;-All resident reported allergies are documented in the medical record;-Severe food allergies are noted on the resident's profile and communicated in writing directly to the dietitian and the director of food and nutrition services;-Meals for residents with severe food allergies are prepared so that cross-contamination with allergens does not occur;-Residents with allergies are offered appropriate substitutions for foods that they cannot eat;-Nursing staff and food service employees are trained in the signs and symptoms of allergic reactions to foods and basic first aid measures in the event of a food allergy emergency.Review of the facility policy titled Interdepartmental Notification of Diet reviewed on 11/01/25, showed the following information:-When a new resident admitted , or a diet changed, the nurse supervisor ensured the food and nutrition services department received a written notice of the diet order;-The food and nutrition services department were notified verbally if the diet change or report occurred one hour or less before a scheduled meal, or if circumstances indicated that only the written procedures would not be adequate to ensure service at the next meal;-Each nursing station shall maintain a supply of diet order/change in diet forms. 1. Review of Resident #1's face sheet (brief look at resident information) showed the following information:-admission date of 03/03/26;-Allergies included beef, beef derived product, grapes, peanuts, wheat, and mountain dew;-Diagnoses include Alzheimer's disease, high blood pressure, and cerebral infarction (a type of ischemic stroke caused by a blockage in an artery supplying blood to the brain, resulting in tissue death(necrosis).Review of the resident's comprehensive Minimum Data Set (MDS-a federally mandated assessment tool filled out by facility staff), dated 03/03/26, showed the following information:-Cognitively impaired;-Required supervision from staff for eating.Review of the resident's care plan, dated 03/03/26, showed staff did not care plan related to the resident's diet or known food allergies.Review of the resident's Nursing Admission/readmission Data Collection assessment, dated 03/03/26, showed the following information:-Allergies included beef derived product, peanuts, and wheat;-No special nutritional needs indicated.Review of the resident's Physician Order Sheet (POS), dated 03/01/26 through 03/31/26, showed an order, dated 03/03/26, for regular diet, regular texture, and regular consistency. The order did not address resident allergies.Review of the resident's progress note dated 03/11/26, at 3:00 P.M., showed the following information:-The resident was sent to the emergency department via ambulance;-The resident was found vomiting and having diarrhea. The resident's vital signs were assessed and the resident became unresponsive on the toilet;-The Director of Nursing (DON) was called into the room and assisted with the transfer of the resident to bed. The resident's feet were elevated in bed;-The resident continued vomiting and was given a basin. Staff attempted to do sublingual (under the tongue) medication and the resident could not absorb the medication;-The resident's family was called and notified of change of condition and of the sending to the emergency department;-The physician was notified.Review of the resident's progress note dated 03/11/26, at 9:24 P.M., showed hospital indicated to nursing staff that the resident was being admitted .Review of the resident's transfer to hospital form. dated 03/11/26, showed the following information:-The resident was not alert at the time of transfer;-Allergies included beef, beef derived product, grapes, peanuts, wheat, and mountain dew.Review of the resident's care plan, created on 03/11/26, showed the following information:-The resident had an allergy to beef, beef derived (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	product, grape, peanut, wheat, and mountain dew;-Document allergies in the chart;-Ensure the resident, family, and staff to communicate information regarding history of allergy or possible allergic reactions.Review of the resident's History and Physical from the hospital stay and resident's facility physician, dated 03/12/26, showed the following information:-The resident admitted to the hospital for an allergy to beef with delayed reaction;-The resident had a beef taco at his/her facility and had an episode of emesis (vomiting) and syncope (collapse);-The resident was sent to the hospital for further eval. There was a concern for aspiration and the resident received Benadryl (over the counter anti-histamine used for allergies), Solu Medrol (a potent, fast acting injectable corticosteroid used to treat severe allergic reactions), and Pepcid (an antagonist that treats heartburn by reducing stomach acid production).Review of the resident's progress note dated 03/13/26, at 11:20 A.M., showed the resident returned to the facility form the hospital with new orders that included an antibiotic.During an interview on 03/17/26, at 1:29 P.M., the Kitchen Manager said the following:-He was aware that the resident had food allergies;-He was in the process of completing all of the resident's dietary card which would show if any resident had an allergy;-He served lunch on 03/11/26, and though he was aware the resident had allergies, the diet order did not indicate that. An order change came through showing the resident allergies after the resident had been served the beef product;-He believed two menu cards were accidently made for the resident, one showing the residents allergies and one that did not show the residents allergies. When making the resident's tray that day, he was given the wrong dietary card;-The incident was investigated and reported to the Administrator and Dietitian;-The expectation was that when a new resident admitted to the facility, the nurse admitting the resident should fill out a diet slip and give it to him and he would fill out the menu name card himself. During an interview on 03/17/26, at 2:06 P.M., Certified Nursing Assistant (CNA) A said the following:-If a resident had food allergies it should be shown on their dietary card;-The typical serving process was he/she would obtain all of the resident's dietary cards and sort them by hall and/or if they eat in the dining room. After he/she sorted the cards, he/she would hand the cards to the Kitchen Manager/server to begin dishing the plates;-Allergies should be shown on the resident's care plan, but aides do not have access to view the care plans;-The resident was sent to the hospital because he/she was served beef;-He/she later saw two dietary cards for the resident. One of the cards had the right room number but did not list allergies, and the other card had the wrong room number but listed the allergies;-The DON filled out the resident's diet on admission, that he/she personally delivered to the Kitchen Manager;-It was later found out that the resident was served beef tacos for lunch which had caused an allergic reaction.During an interview on 03/18/26, at 10:07 A.M., Certified Medication Technician (CMT) B said the following:-The residents face sheet showed any allergies a resident had;-Allergies should be care planned, though CMT's cannot view the care plans;-Dietary cards show allergies;-He/she was working the day of the incident and observed the resident eating a beef taco. At the time, he/she was not aware that the resident had any allergies. He/she was in the dining room passing medications and even asked the resident if he/she enjoyed his/her lunch. He/she indicated that he/she didn't have complaints, it was his/her body that disagreed with beef;-Shortly after, the resident went back to his/her room and when nursing assistants assisted him/her to the bathroom, one of them came out of the room and was saying that the resident was having excessive amounts of diarrhea and vomiting;-The nurse on duty went to the resident's room and begin assessing the resident, his/her oxygen was lower than normal and he/she was awake but not responding to stimuli;-One of the nurses discovered that he/she had an allergic reaction;-Allergies should be documented immediately upon admission and diet orders and allergies should be communicated with dietary.During an interview on 03/18/26, at 10:39 P.M., Licensed Practical Nurse (LPN) C said the following:-Staff was aware of a resident's allergies by the admission orders that the nurse puts into place. Additionally, staff should be able to see resident allergies to food on the resident's dietary card;-There used to be slips that the admitting nurse would fill out and give to the Kitchen Manager, but now the expectation is just to communicate with the Kitchen (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Manager and he will fill out the dietary card himself;-He/she was aware the DON made the resident's menu name card and gave it to the Kitchen Manager, but somehow the resident ended up with an additional dietary card that did not list his/her allergies;-Allergies should be care planned;-If a resident were served food they were allergic to, there is potential to aspirate with excessive vomiting, additionally a resident could present with respiratory distress.During an interview on 03/18/26, at 12:08 P.M., the DON said the following:-Staff were aware of resident's allergies by looking at the resident's dietary cards. Additionally, the face sheet would show any allergies, as well as the care plan;-When a new resident admitted to the facility, the nurse was expected to enter the allergies into the residents POS and print that out and give it to the Kitchen Manager;-She was aware of the incident with the resident. A nurse came and got her and told her that the resident was having excessive vomiting and diarrhea. No one realized at the time that the resident had been served beef. Eventually she checked the resident's allergies and asked the kitchen staff what the resident had to eat for lunch. This showed he/she had consumed beef;-She went through the dietary cards and noticed that the resident had two cards. One card was accurate with the resident's allergies and the other card did not list the resident's allergies; -She had entered the allergies into the allergies tab in the resident's electronic medical record, she did not add the allergies to his/her diet order but wrote them down and verbally told the Kitchen Manager the resident's allergies on admission.During an interview on 03/18/26 at 1:35 P.M., the MDS Coordinator said the following:-She was responsible for the care plans, though nursing staff is able to also enter information;-Care plans should include a resident's diet and any food allergies.During an interview on 03/19/26, at 1:14 P.M., the dietitian said the following:-She was aware of the incident with the resident;-Nursing staff should notify dietary of a resident's diet and any allergies upon admission and the Kitchen Manager should document that on the dietary cards.During an interview on 03/18/26, at 1:48 P.M., the Administrator said the following:-She expected staff to know resident allergies by observing the resident's admission documentation, communicating with the resident and family, and the resident's history and physical;-Allergies were expected to be care planned and a diet order should show any allergies;-The diet order should be completed on admission and a copy should be given to the Kitchen Manager. The Kitchen Manager should document the resident's diet and any food allergies on the resident's dietary card immediately;-There was a possibility for aspiration with the resident vomiting to the extent noted;-She completed an investigation regarding the incident with the resident and found that there were two dietary cards made for the resident. One of the cards was accurate and the other card did not list the resident's allergies, evidently that is the card that was used on the day of the incident.Complaint #2803841