STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265571	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ash Grove Healthcare Facility	401 North Medical Drive Ash Grove, MO 65604

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care per standards of practice when staff failed to complete weekly skin assessments, document accurate wound assessments, obtain orders timely, follow physician orders, and provide treatment as ordered for one resident (Resident #1) who admitted with multiple identified wounds. The facility census was 78.Review showed the facility did not provide a policy regarding wound care. Review of a facility policy titled Assessments in Long Term Care, dated January 2025, showed the following:-Licensed nursing staff will begin to initiate an admission assessment when the patient presents to the nursing unit;-The purpose of this policy is to provide an initial assessment to use as a baseline and to provide reassessments as needed is a change is indicated for the patient's response to care, condition changes, and diagnosis;-Assessments may be completed when there is a significant change in the patient's condition, diagnosis, or to determine patient's response to care;-The nursing care plan will be initiated according to identified needs from the admission assessment;-Licensed nursing personnel will update care plans as needs are assessed. Review of a facility policy titled, Medication Orders, , dated January 2025, showed the following:-Medication orders will be carried out when given by a physician;-Treatment orders shall be entered into the patient's electronic medical record. 1. Review of Resident #1's face sheet (document that gives resident's information at a quick glance) showed the following:-admission date of 09/05/2025;-Diagnoses included coronary artery disease (condition where the arteries that supply blood to the heart become narrow or blocked), peripheral vascular disease (circulatory disorder that narrows and hardens arteries and veins outside the heart and brain), and high blood pressure. Review of the resident's hospital wound treatment note, dated 09/03/25, showed new areas of concern on the right foot appear to be vascular related. Review of resident's hospital Discharge summary, dated [DATE], showed resident had new vascular-related skin lesions to the right foot. Right foot had scattered areas of erythema (redness) and ecchymosis (bruise) to the plantar (sole of the foot) aspect of the right foot. Dressing change in one week per podiatrist. Review of the resident's nursing admission note, dated 09/05/25, showed resident had multiple wounds to bilateral lower extremities and had considerable pain with wounds and surgical incision. Review of the resident's skin assessment, dated 09/05/25, showed the following:-A callus to the right distal great toe that was black in color;-A callus to the right medical foot that was black in color;-An abrasion to the right lateral (side) foot with a moist pink wound bed;-A skin tear to the right posterior lateral ankle with a moist pink wound bed;-A skin tear to the left lower calf with a moist, pink wound bed;-A skin tear to the right lower calf with a moist, pink wound bed.Review of the resident's September 2025 Physician's Orders (POS) showed the staff did not document treatment order related to the identified areas. Review of the resident's physical therapy evaluation, dated 09/06/25, showed resident had both feet wrapped in bandages. Left lower extremity wrapped from surgery and the right lower extremity wrapped due to open blisters. Review of resident's September 2025 POS showed an order, dated 09/08/25, to cleanse areas of eschar to right foot with wound cleanser, any open areas, then apply padded dry dressing and wrap with kerlix (cotton gauze bandage). Keep surgical site clean with wound cleanser and wrap rest of foot with kerlix daily. (Staff obtained and documented order three days after admission date with identified areas. Staff did not document treatment orders for resident's skin tears.)Review of the resident's September 2025 skin treatment records showed staff did not document completion of wound treatments 09/10/25 and 09/15/25. Review of the resident's skin assessment, dated 09/12/25, showed the following:-A callus to the right distal great toe that is black in color;-A callus to the right medical foot that is black in color;-An abrasion to the right lateral (side) foot with a moist pink wound bed;-A callus to the right heel that was black in color;-A skin tear to the right posterior lateral ankle with a moist pink wound bed;-A skin tear to the left lower calf with a moist, pink wound bed;-A skin tear to the right lower calf with a moist, pink wound bed.(Staff did not document a full assessment to include sizes of the areas.) Review of the resident's September 2025 POS showed the staff did not document treatment order related to the skin tears.Review of the resident's September 2025 skin treatment records showed staff did not document completion of wound treatments 09/18/25.Review of a wound assessment, dated 09/19/25, showed the following:-Surgical wound two weeks post-surgery and able to remove dressing today. Measuring 2.5 cm in length with no width and treatment indicated as cleanse and wrap with kerlix (physician order showed cleanse and wrap surgical site with kerlix dated 09/08/25).Review of the resident's skin assessment, dated 09/19/25, showed the following:-A callus to the right distal great toe

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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. (continued on next page)

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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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care per standards of practice when staff failed to complete weekly skin assessments, document accurate wound assessments, obtain orders timely, follow physician orders, and provide treatment as ordered for one resident (Resident #1) and failed to provide treatments as ordered for one resident (Resident #2) with pressure ulcers (localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device). The facility census was 78.Review showed the facility did not provide a policy regarding wound care. Review of a facility policy titled Assessments in Long Term Care, dated January 2025, showed the following:-Licensed nursing staff will begin to initiate an admission assessment when the patient presents to the nursing unit;-The purpose of this policy is to provide an initial assessment to use as a baseline and to provide reassessments as needed is a change is indicated for the patient's response to care, condition changes, and diagnosis;-Assessments may be completed when there is a significant change in the patient's condition, diagnosis, or to determine patient's response to care;-The nursing care plan will be initiated according to identified needs from the admission assessment;-Licensed nursing personnel will update care plans as needs are assessed. Review of a facility policy titled, Medication Orders, , dated January 2025, showed the following:-Medication orders will be carried out when given by a physician;-Treatment orders shall be entered into the patient's electronic medical record. 1. Review of Resident #1's face sheet (document that gives resident's information at a quick glance) showed the following:-admission date of 09/05/2025;-Diagnoses included coronary artery disease (condition where the arteries that supply blood to the heart become narrow or blocked), peripheral vascular disease (circulatory disorder that narrows and hardens arteries and veins outside the heart and brain), and high blood pressure.Review of the resident's hospital wound treatment note, dated 09/03/25, showed the resident had a pressure injury to the right heel measuring 0.6 centimeters (cm) in length and 0.8 cm in width with a black moist eschar (a layer of dead tissue that forms over a wound) wound base. Review of resident's hospital Discharge summary, dated [DATE], showed resident had a right heel pressure injury with black eschar. Dressing change in one week per podiatrist. Review of the resident's nursing admission note, dated 09/05/25, showed the resident had multiple wounds to bilateral lower extremities and had considerable pain with wounds and surgical incision. Review of the resident's physical therapy evaluation, dated 09/06/25, showed resident had both feet wrapped in bandages with left lower extremity wrapped from surgery and the right lower extremity wrapped due to open blisters. Review of the resident's wound assessment, dated 09/05/25, showed the following:-Left calf stage 2 pressure ulcer (a partial-thickness skin loss presenting as a shallow open ulcer with a red or pink wound bed, without slough (layer of dead, yellow tissue that separates from the underlying healthy tissue)) measuring 2 cm in length by 1 cm width with a depth of 0.1 cm; -Right heel stage 2 pressure ulcer measuring 2 cm in length by 2.5 cm width with a depth of 0.1 cm. (Staff did not document related to the appearance of the wound bed or drainage.)Review of the resident's September 2025 Physician Orders showed an order, dated 09/08/25, to cleanse areas of eschar to right foot with wound cleanser, any open areas, then apply padded dry dressing and wrap with kerlix (cotton gauze bandage). (Staff obtained and documented order three days after the resident's admission with an identified pressure ulcer to the right heel. Staff did not document an order for pressure ulcer identified on the resident's left calf.) Review of the resident's September 2025 skin treatment records showed staff did not document wound care provided on 09/10/25. Review of the resident's wound assessment, dated 09/12/25, showed the following:-Left calf stage 2 pressure ulcer (staff did not document size and full description of the wound); -Right heel stage 2 pressure (staff did not document size and full description of the wound).Review of the resident's September 2025 skin treatment records showed staff did not document wound care provided on 09/15/25 and 09/18/25.Review of the resident's wound assessment, dated 09/19/25, showed the following:-Left calf stage 2 pressure ulcer measuring 2 cm by 1 cm with wound treatment indicated as scabbed over (staff did document a full assessment of the appearance of the wound);-Right heel stage 2 pressure ulcer measuring 2 cm by 2.5 cm with wound treatment indicated as scabbed over (staff did document a full assessment of the appearance of the wound). Review of the resident's September 2025 skin treatment records showed staff did not document wound care provided on 09/20/25.Review of the resident's facility transfer report, dated 09/21/25, showed the resident had an amputation of the left second toe and multiple areas of dark stable eschar on right lower