

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265336	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/23/2025
NAME OF PROVIDER OR SUPPLIER Carriage Square Rehab and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4009 Gene Field Road Saint Joseph, MO 64506	
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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265336	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/23/2025
NAME OF PROVIDER OR SUPPLIER Carriage Square Rehab and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4009 Gene Field Road Saint Joseph, MO 64506	
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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on observation, interview, and record review the facility failed to ensure that two resident's (Resident # 1 and #3) who had urinary catheter (a tube inserted into the bladder to drain urine from the body), received appropriate treatment and services to prevent urinary tract infections when the facility failed to provide proper catheter care management. This deficient practice affected two of the four sampled resident's. The facility census was 89. Review of the facility polity titled, Catheter-Care, dated 10/24/22, showed: -Purpose: to prevent catheter associated urinary tract infections while ensuring that residents are not given indwelling catheters unless medically necessary; -Cleanse the outside of the catheter wiping away from the meatus; -Take care to ensure the collection bag does not touch the floor at any time. 1. Review of Resident #1's care plan, revised 9/19/25, showed: -The resident had limited physical mobility related to weakness; - The resident was incontinent of bowels; -The resident had a suprapubic catheter (a tube placed directly in the bladder through a small incision in the abdomen used to drain urine); -The resident was dependent on nursing staff to manage and care for the suprapubic catheter. Review of The Resident's After Visit Summary from the Emergency Department, dated 10/25/25, showed: -The resident had been seen for urinary retention; -The resident had a diagnosis of a urinary tract infection associated with indwelling suprapubic catheter; -The resident was prescribed Cefpodoxime (an oral antibiotic medication used to treat the urinary tract infection); -A new catheter was inserted while at the Emergency Department. Observation on 12/23/25 at 10:25 A.M. showed: -The resident's catheter bag (a bag that holds the collected urine) was touching the floor underneath his/her wheelchair while the resident sat in the hallway, rather than up off the floor in a collection dignity bag cover; -Licensed Practical Nurse (LPN) A pushed the resident to the nurses station in his/her wheelchair to put topical medication on the resident's knees, LPN A did not secure the resident's catheter bag off of the floor during this encounter. Observation on 12/23/25 at 12:21 P.M. showed: -Certified Nursing Assistant (CNA) A performed catheter care to the resident' suprapubic catheter; -CNA A cleansed the resident's catheter tubing in a back and forth motion using the same soiled wipe and with the same gloves used to pick up and move the trashcan. 2. Review of Resident #3's care plan, revised dated 10/08/25, showed: -The resident was incontinent of bowels; -The resident had an indwelling urinary catheter (a tube inserted through the urethra into the bladder to drain urine); -The resident was dependent on nursing staff to care for the resident's catheter and incontinence needs. Observation on 12/23/25 at 12:04 P.M. showed: -CNA A performed catheter care on the resident's urinary catheter; -CNA A scrubbed the tubing of the catheter in a back and forth motion using. During an Interview on 12/23/25 at 12:35 P.M. CNA A said: -There is usually a rubber band that holds Resident #1's catheter bag and tubing off of the ground, the rubber band keeps falling off and then his/her bag and tubing touches the ground; -He/She did not know that a wipe was only to be used for one swipe when performing catheter care. -Catheter bags and tubing should not be laying on the floor. During an Interview on 12/23/25 at 1:14 P.M. LPN A said: -An isolation gown and clean gloves should be worn when performing catheter care; -When cleaning catheter tubing one wipe should be used to clean down the tubing wiping away from the resident, then a new wipe should be used each time cleaning down the tubing; -It was hard to keep resident's catheter bag and tubing off of the floor; -Catheter bags and catheter tubing should not touch the floor. During an Interview on 12/23/25 at 1:20 P.M. CNA B said: -An isolation gown and clean gloves should be worn when doing catheter care; -When performing catheter care wipe down the catheter tubing away from the insertion site using a new wipe each time; - Catheter tubing and catheter bags should not touch the floor. During an Interview on 12/23/25 at 2:00 P.M The Director of Nursing (DON) said: -When performing catheter care wipe down the tubing cleaning away from the body using a new wipe each time; -Staff should wash hands and change gloves after touching other items before performing catheter care. -Catheter bags and tubing should not touch the floor. Intake 2690286</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265336	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/23/2025
NAME OF PROVIDER OR SUPPLIER Carriage Square Rehab and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4009 Gene Field Road Saint Joseph, MO 64506	
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 - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections when the facility failed to ensure enhanced barrier precautions (EBP) and infection control measures were used during high-contact care for residents with wounds (Resident #3 and 4) and indwelling devices Resident #1 and 3), were being utilized for three (Resident's #1, 3, and 4) of four sampled residents. The facility census was 89. Review of the facility policy titled, Standard and Enhanced Precautions, dated 7/1/23, showed: -Enhanced precautions will be used for residents with indwelling urinary catheters and for residents with wounds or presence of unhealed pressure ulcer;- The facility staff were supposed to perform hand hygiene when providing cares;- The staff were supposed to wear a gown when providing resident cares that were likely to generate a spray or splash of bodily fluids.</p> <p>1. Review of Resident #3's Minimum Data Set (MDS, a federally mandated assessment tool completed by the facility staff), showed:-The resident had a brief interview for mental status (BIMS) score of 15, indicating no cognitive impairment;- Diagnoses included: Cellulites (inflammation of the skin) of the left and right leg, chronic venous insufficiency (the blood does not pump through the veins properly), weakness, and need for assistance with personal cares, and wounds to both legs.</p> <p>Review of the resident's Enhanced Barrier Precaution (EBP) care plan dated 7/21/25 showed:- The resident was on EPB precautions;- The staff were supposed to wear personal protective equipment (PPE) when performing high contact resident care.</p> <p>Review of the resident's physician order sheet (POS) dated December 2025 showed:- 11/11/25 Resident is on catheter (tube that enters the body to drain urine outside of the body) and wounds;- 12/2/25 Clean right lower leg ulcers (wounds) with hydrochlorus acid (wound cleaning solution), Allow hydrochorus soaked gauze to sit on the wounds for three minutes, then wipe out in a circular motion. Apply adaptic screen (wound dressing) over the wounds, Cover the screen with Aquacel Alginate (wound covering) cut to the size of the wound, secure with an abdominal pad and roll gauze. Change the dressing every shift and as needed;- 12/2/25 Clean left lower leg ulcers (wounds) with hydrochlorus acid (wound cleaning solution), Allow hydrochorus soaked gauze to sit on the wounds for three minutes, then wipe out in a circular motion. Apply adaptic screen (wound dressing) over the wounds, Cover the screen with Aquacel Alginate (wound covering) cut to the size of the wound, secure with an abdominal pad and roll gauze. Change the dressing every shift and as needed.</p> <p>During an interview on 12/23/25 at 9:25 A.M. the resident said:- He/She had issues with staff completing his/her wound care;- The staff don't always wash their hands or wear gowns when they complete his/her wound care;- He/She just returned to the facility from the hospital after being treated for wound infections.</p> <p>Review of the resident's hospital records dated 10/23/25 showed:- The resident was admitted to the hospital on [DATE] with wound infections of both legs;- The resident was discharged back to the facility on [DATE].</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265336	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/23/2025
NAME OF PROVIDER OR SUPPLIER Carriage Square Rehab and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4009 Gene Field Road Saint Joseph, MO 64506	
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 - Some</p>	<p>Review of the resident's hospital records dated 11/21/25 showed:- The resident was admitted to the hospital on [DATE] with cellulitis of both legs and infection of the legs wounds of both legs;- The resident was discharged back to the facility on [DATE].</p> <p>Observation on 12/23/25 at 10:34 A.M. showed:- Registered Nurse (RN) A entered the resident's room, did not perform hand hygiene and did not put on a protective gown;- RN A put on a pair of gloves;- RN A pulled back the resident's blanket;- Both of the resident's lower legs were wrapped in roll gauze that was dirty with a red/ brown substance;- RN A began removing the old dressing from the resident's right leg;- RN A touch his/her face, nose and glasses with his/her contaminated gloved hands and continued to remove the dressing from the resident's right leg;- RN A removed the resident's dressing to his/her right leg and threw the dressings in the trash can;- RN A then picked up the trash bag from the can with his/her gloved hand and set the bag on the foot of the bed;- RN A did not change his/her gloves or perform hand hygiene;- RN A removed his/her gloves and left the resident's room at 10:47 A.M., RN A returned to the resident's room at 10:50 A.M. with additional wound supplies;- RN A put on clean gloves, did not perform hand hygiene, picked up the trash bag with his/her gloved hand from the foot of the bed and set the bag on the floor;- RN A placed a new wound dressing to the resident's right leg with his/her contaminated gloves;- RN A removed his/her gloves at 10:56 A.M. and left the residents room again and returned a few minutes later with Licensed Practical NURse (LPN) A;- Neither RN A or LPN A performed hand hygiene or put on a protective gown;- LPN A put on gloves and lifted the resident's right leg;- RN A placed clean dressing to the back of the resident's right leg;- RN A touch his/her nose with his/her gloved hand and then placed a new dressing to the resident's wounds;- RN A removed his/her gloves went to the sink and washed his/her hands with perineal wash (wash intended to be used for personal care), and put on clean gloves;- RN A removed the dressing from the resident's left leg and threw the old dressings to the floor;- The dressings made a splat sound when they hit the floor;- RN A did not change his/her gloves after removing the old dressing and began applying a clean dressing to the front of the resident's left leg;- LPN A lifted the resident's left leg and RN A cleaned the back of the leg and threw the used cleaning supplies to the floor;- RN A wiped his/her nose on the back of his her gloved hand, clear drainage could be seen on the back of RN A's glove;- RN A did not change his/her gloves or perform hand hygiene;- RN A continued to apply clean dressing to the resident's left leg;- LPN A removed his/her gloves, did not perform hand hygiene, and left the resident's room;- RN A completed the dressing change, removed his/her gloves and left the room.</p> <p>During an interview on 12/23/25 at 1:34 P.M. RN A said:- He/She should have worn a gown when he/she provided wound care for the resident;- He/She should have washed his/her hands with each glove change;- He/She should not have touched the trash bag with his/her gloved hands;- He/She should not have thrown used wound dressings on the floor;- He/She should have changed his/her gloves and washed his/her hands after touching his/her face and wiping his/her nose.</p> <p>During an interview on 12/23/25 at 1:15 P.M. the Director of Nursing (DON) said:- She expected all staff that participate in the resident's wound care to wear a protective gown and gloves;- She expected the staff to wash their hands with each glove change;- She expected the staff to change their gloves between taking an old wound dressing off and placing a new dressing on;- She expected staff to remove their gloves, perform hand hygiene and place new gloves on when staff touch their face, wipe their nose on their gloves, and touch the trash can;- She expected staff to throw old wound dressing in the proper receptacle, not on the floor.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265336	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/23/2025
NAME OF PROVIDER OR SUPPLIER Carriage Square Rehab and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4009 Gene Field Road Saint Joseph, MO 64506	
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 - Some</p>	<p>2. Review of Resident #4's face sheet dated December 2025 showed diagnoses included a Pressure Ulcer (wound) to his/her left heel and reduced mobility.</p> <p>Review of the residents EBP care plan dated 3/11/25 showed:- The resident was on EBP precautions for a wound;- The staff were supposed to wear PPE when performing high contact resident care.</p> <p>Review of the resident's POS dated December 2025 showed the following:- 2/20/25 EBP precautions;- 11/11/25 Cleanse the left heel with normal saline (wound cleanser), blot dry. Apply skin prep (a skin protectant) around the wound edges, apply calcium alginate to the wound bed, and cover with a foam dressing. Change every Tuesday on day shift.</p> <p>Observation on 12/23/25 at 2:30 P.M. showed:- Infection Preventionist (IP) entered the residents room with the dressing change supplies on a plastic tray;- The resident was in his/her wheel chair wearing socks and no shoes on both feet, facing the bed;- The IP placed the tray on the resident's bed;- The IP put on clean gloves;- The IP squatted in front of the resident, picked the resident's left foot up and removed the resident's sock;- The IP placed the dirty sock on top of the clean dressings on the plastic tray;- The IP removed the old dressing from the resident's heel, removed his/her gloves, applied hand sanitizer and put on a clean pair of gloves;- The IP cleaned the wound on the residents heel, removed his her gloves, performed hand hygiene and put on clean gloves;- The IP moved the dirty sock from on top of the clean dressings with his/her gloved hand and placed the sock on the end of the bed;- The IP did not change his/her gloves and continued with the dressing change.</p> <p>During an interview on 12/23/25 at 3:00 P.M. The IP said:- He/She should not have laid a dirty sock on the clean wound dressing supplies;- He/She should have gotten clean supplies once he/she contaminated them with the dirty sock;- He/She should have removed his/her gloves, performed hand hygiene and put on clean gloves when he/she touched the dirty sock;- He/She should not have continued changing the residents dressing once she touched the dirty sock.</p> <p>During a follow up interview on 12/23/25 at 3:15 P.M. The DON said:- She would have expected staff to retrieve new dressing supplies when the current supplies were contaminated with a dirty sock;- She would have expected staff to change their gloves and perform hand hygiene when they touched a dirty sock and before they touched the resident wound;</p> <p>3. Review of the facilities Catheter-Care of policy, dated 10/24/22, showed: -Purpose: to prevent catheter associated urinary tract infections while ensuring that residents are not given indwelling catheters unless medically necessary; -Cleanse the outside of the catheter wiping away from the meatus; -Take care to ensure the collection bag does not touch the floor at any time.</p> <p>4. Review of Resident #1's care plan, revised 09/19/25, showed: -The resident was dependent on nursing staff for catheter care and personal hygiene and grooming needs; -The resident was incontinent of bowels; -The resident had a suprapubic catheter (a tube placed directly in the bladder through a small incision in the abdomen used to drain urine); -The resident was on EBP precautions for urinary catheter.</p> <p>Observation on 12/23/25 at 10:25 A.M. showed: -The resident's urinary catheter bag was touching the floor underneath his/her wheelchair while the resident sat in the hallway; -Licensed Practical Nurse (LPN) A brought the resident to the nurses station in his/her wheelchair, LPN A did not secure the resident's urinary catheter bag off of the floor during this encounter.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265336	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/23/2025
NAME OF PROVIDER OR SUPPLIER Carriage Square Rehab and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4009 Gene Field Road Saint Joseph, MO 64506	
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 - Some</p>	<p>Observation on 12/23/25 at 12:21 P.M. showed: -Certified Nursing Assistant (CNA) A performed urinary catheter care to resident's suprapubic catheter; -CNA A used hand sanitizer, and applied gloves, CNA A did not wear an isolation gown during catheter care; -CNA A then picked up the trash can in the resident's room wearing the same gloves initially applied when beginning catheter care; -CNA A cleansed the resident's catheter tubing in a back and forth motion using the same soiled wipe while wearing the same gloves used to pick up and move the trashcan.</p> <p>5. Review of Resident #3's care plan, revised 10/8/25, showed: -The resident was incontinent of bowels; -The resident had an indwelling urinary catheter (a tube inserted through the urethra into the bladder to drain urine); -The resident was on EBP precautions for the urinary catheter; - The resident was dependent on nursing staff to maintain and provide urinary catheter care and personal hygiene needs.</p> <p>Observation on 12/23/25 at 12:04 P.M. showed: -CNA A performed urinary catheter care for the resident; -CNA A used hand sanitizer and applied clean gloves, CNA A did not apply an isolation gown; -CNA A picked up the trashcan in the resident's room and moved it closer to the bed; -CNA A scrubbed the tubing of the catheter in a back and forth motion using the same gloves used to pick up the trashcan.</p> <p>6. During an Interview on 12/23/25 at 12:35 P.M. CNA A said: - Urinary catheter bags and tubing should not be touching the floor; -He/She should have changed gloves after picking up and moving the trashcan before providing catheter care; -He/She should have worn an isolation gown along with gloves when performing catheter care.</p> <p>During an Interview on 12/23/25 at 1:14 P.M. LPN A said: -An isolation gown and clean gloves should be worn when performing catheter care; -The catheter bag and tubing should not be touching the floor.</p> <p>During an Interview on 12/23/25 at 1:20 P.M. CNA B said: -An isolation gown and clean gloves should be worn when doing catheter care; -Catheter tubing and catheter bags should not touch the floor.</p> <p>During an Interview on 12/23/25 at 2:00 P.M The Director of Nursing (DON) said: -An isolation gown and clean gloves should be worn when performing catheter care; &nb</p>		