STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265336	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carriage Square Rehab and Healthcare Center	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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide services that met professional standards of quality when the facility staff failed to follow physician orders to be notified of high blood glucose levels (Resident #5), when the facility staff failed to prime the needle of an insulin pen prior to administration (Resident #6) and additionally when the facility staff failed to ensure they had all required supplies for central line (a long, flexible tube inserted in a vein and into the heart) dressing change prior to initiation of dressing change (Resident #4). This affected three residents. The facility census was 85.Review of the facility policy titled Care and Services dated 10/24/22, showed the facility will have sufficient staff to provide services to residents with the appropriate competencies and skill sets to provide nursing services to assure resident safety and maintain the highest practicable physical, mental and psychosocial well-being and that the licensed nurses are to document and notify physicians and responsible parties of changes in condition, refusal of cares or services and unusual circumstances. Review of the facility policy titled Diabetic Care dated 10/24/22, showed:-Blood glucose levels will be monitored at specific intervals as ordered by the physician;-When a resident's blood glucose is greater than 400, the physician must be notified;-Facility staff are to document in the resident's medical record: any symptoms, interventions, response to treatment and physician notification. Review of the facility policy titled Subcutaneous Injection/Insulin or Heparin dated 10/24/22 showed no information, guidance, regulations, policy or procedures for insulin pens (portable devices used to inject insulin). Review of the facility policy titled Dressing Change for Vascular Access Devices dated 08/21, showed-Dressing changes are completed to prevent local and system infection related to the Intravenous (IV) catheter;-Supplies needed: Central Line Dressing Change Kit, Engineered stabilization device (Stat-Lock), clean gloves, sterile gloves;-Staff are to wash hands, put on clean gloves, remove the old dressing including impregnated gauze sponge (BioPatch) and stabilization device;-Apply sterile gloves, clean area larger than dressing to be applied, apply BioPatch and sterile tape or stabilization device if applicable;-Apply transparent dressing, remove gloves, perform hand hygiene and document dressing change and resident response to procedure in medical record. Review of Resident #5's Significant Change Minimum Data Set (MDS-a federally mandated assessment completed by facility staff), dated 06/02/26, showed:-No cognitive impairment;-He/She was dependent on staff for toileting, transfers, hygiene, mobility and transfers;-Incontinent of bowel and bladder;-Received insulin injections daily;-Diagnoses included heart failure, chronic kidney disease and Diabetes. Review of the resident's care plan dated 06/04/26, showed:-He/She required assistance from staff for all grooming and personal cares;-He/She required oral medications and insulin injections to manage Diabetes;-Staff are to provide and document continued Diabetes education. Review of the residents' Electronic Medical Record (EMR) dated 05/23/26-06/04/26 showed:-Physician order dated 05/23/26 that provider to be notified each time Bedside Blood Glucose (BSBG) was greater than 400;-BSBG greater than 400 on the following dates and times: 05/24/26 at 1:00P.M., 05/25/26 at 8:13P.M., 05/26/26 at 4:17P.M., 05/27/26 at 8:35P.M., 05/28/26 at 9:09A.M. and 12:35P.M., 05/29/26 at 8:30A.M., and 8:23P.M., 05/30/26 at 7:57A.M., and 4:39P.M., 05/31/26 AT 7:27A.M. and 12:11P.M., 06/01/26 at 1:04P.M. and (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5:43P.M., 06/02/26 at 9:01A.M., 12:21P.M., and 5:59P.M., 06/03/26 at 7:40A.M. and 11:10A.M.-05/26/26 nurse's note that a call was placed to the Nurse Practitioner (NP) and NP was notified of elevated BSBG;-05/28/26 two additional comments on insulin administration records that provider had been notified of elevated BSBG;-05/29/26 nurse's note that the facility's nurse practitioner was in house and increased insulin dosages;-06/02/26 nurse's note that an order was received to increase insulin dosage;-06/03/26 nurse's note that there were new insulin orders and oral anti-diabetic medications added. Review of Resident #5's Comprehensive MDS dated [DATE] showed:-No cognitive impairment;-Assistance needed from staff for toileting and hygiene tasks;-Diagnoses included heart failure, kidney disease and Diabetes. Review of the resident's care plan dated 06/04/26, showed:-He/She required assistance with bathing, hygiene and transfers;-He/She required oral medications and insulin injections to manage Diabetes;-He/She had an alteration in neurological status related to seizure disorder. Observation on 06/04/26 at 11:40A.M., showed RN A preparing insulin for administration:-RN A assessed BSBG, reviewed physician order to confirm dosage;-RN A opened insulin pen, wiped rubber seal with an alcohol pad and then applied disposable insulin needle;-RN A did not prime the insulin needle;-RN A turned dial on insulin pen to dosage for administration, RN A administered insulin, disposed of needle in sharps container, exited room and documented insulin administration. Review of Resident #4's Comprehensive MDS dated [DATE], showed:-No cognitive impairment;-He/She had a central line for long-term antibiotic use;-Diagnoses included osteomyelitis, high blood pressure and chronic kidney disease. Review of the resident's care plan dated 06/04/26, showed:-He/She was at risk for falls related to gait instability;-He/She had chronic wounds to foot and ankle;-No interventions, goals or orders related to long-term antibiotic use, chronic wounds or central line use and care. Observation on 06/04/26 at 3:03P.M., showed:-RN A entered and exited room several times prior to start of central line dressing change to obtain supplies;-RN A removed old dressing and asked surveyor to ask nurse in hall to obtain additional supplies;-RN A exited resident's room, with central line insertion site open to air, to obtain additional supplies;-Licensed Practical Nurse A (LPN) came into resident's room without wearing a protective gown, gloves or mask;-Resident's central line insertion site was exposed/without a covering or dressing for greater than ten minutes. During an interview on 06/04/26 at 4:04P.M., RN A said that the facility's nursing leadership was unable to find additional supplies (Stat Lock), so a piece of sterile tape was utilized to stabilize the central line before a transparent dressing was placed and additionally, that the facility's pharmacy was notified and supplies had been ordered. During an interview on 06/04/26 at 4:43P.M., RN A said:-There is no need to prime an insulin needle prior to use;-Each time a resident has a BSBG greater than 400, the provider should be notified;-The nurse should document in resident's medical record each time the provider was notified;-He/She should have read the central line dressing change kit inventory more thoroughly as the items that he/she thought were missing needed to be obtained individually as those items were not included in the pharmacy provided kit. During an interview on 06/04/26 at 5:17P.M., the Director of Nursing (DON) said:-Staff are to prime insulin needles with two units and then expel insulin prior to each insulin administration to ensure patency of needle;-Each time a resident has a BSBG greater than 400, a physician or their representative should be notified;-Each time the provider is notified of elevated BSBG, the nurse should document that in a nurse's note whom he/she spoke with and the provider response. Intakes 3031338 and 3031624

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **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 when the facility staff failed to change gloves and perform hand hygiene between dirty and clean tasks when staff did not wipe all areas affected by urine while staff performed perineal hygiene incorrectly for one resident (Resident #1); when the facility failed to provide a barrier between the residents' catheter drainage bag (a tube inserted into the bladder to drain the urine to an external collection device) and the floor for one resident (Resident #2); when the facility staff failed to wear an isolation gown when transferring or providing cares to residents that required Enhanced Barrier Precautions (EBP-infection control measures used to prevent the spread of infection to those at increased risk) for two residents (Residents #3, #4). This affected four sampled residents. The facility census was 85.Review of the facility's Standard and Enhanced Precautions Policy, dated 04/01/24, showed:-Standard precautions apply to all residents regardless of suspected or confirmed presence of infectious diseases.-EBP refers to an infection control intervention that ensures gown and glove use during high contact resident care activities.-For residents that EBP is indicated, EBP should be worn when dressing, bathing, showering, providing hygiene, incontinence cares or toileting, device care or use: central line (a long, flexible tube inserted into a vein in the and advanced until it rests inside the heart), urinary catheter or during dressing changes or wound care. Review of the facility's Perineal Care Policy dated 10/24/22, showed that staff are to wash hands, provide privacy, put on gloves, provide perineal care by spreading the labia and cleaning the urethra, using care to wipe from front to back and away from vaginal opening or wash the penis from urethral opening at tip to base; wash and dry buttocks without contaminating perineal area, place dry linens or brief, remove gloves and wash hands or use Alcohol Based Hand Rub (ABHR), put on new gloves, gather dirty supplies and place in proper container, remove gloves and wash hands. 1.Review of Resident #1's Significant Change Minimum Data Set (MDS- a federally mandated assessment completed by facility staff) dated 05/15/26, showed:-Severe cognitive impairment;-Resident dependent on nursing staff for all transfers, toileting, hygiene and grooming;-Diagnoses included stroke, high blood pressure and Non-Alzheimer's dementia. Review of the resident's care plan dated 06/04/26, showed:-He/She required assistance from nursing staff for dressing, grooming, toileting and hygiene;-He/She was at risk for skin breakdown related to urinary and bowel incontinence;-He/She required assist of staff for bed mobility (repositioning and turning when in bed). Observation of the resident on 06/04/26 at 11:21A.M., showed:-Certified Nurses Assistant (CNA) #1 and Assistant Director Of Nursing (ADON) transferred the resident into bed using a mechanical lift, while the resident was suspended in the lift sling, his/her pants were saturated with urine and the protective pad in wheelchair was wet with urine;-CNA #1 pulled the residents wet pants down around resident's calves when lying in bed;-CNA #1wiped both sides of the groin down and tucked wipes into the incontinent brief;-CNA #1 wiped the perineal area without separating the labia and cleaning the vaginal opening/cleaning the urethral opening, and tucked wipe in between resident's legs;-ADON rolled resident to the right, CNA #1 removed gloves and put on new without performing hand hygiene;-CNA #1 wiped resident's left buttock from the bottom of his/her back towards urethral opening and tucked wipe in between legs;-CNA #1 removed soiled brief, placed in trash and placed a clean brief underneath the resident;-Resident was rolled to the left, staff repositioned the clean brief and did not wipe the right buttock;-Resident was assisted onto his/her back, CNA #1 removed the wet pants from resident's legs and placed directly on resident's bed;-CNA #1 reached into his/her pocket, obtained a roll of trash bags, opened a bag and placed soiled pants inside the trash bag;-ADON removed gloves, applied new gloves and put pants on the resident;-ADON and CNA #1 used mechanical lift to transfer resident into wheelchair, CNA #1 removed gloves, did not perform hand hygiene, took mechanical lift from room, came back to retrieve resident and pushed him/her to dining (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room. 2.Review of Resident #2's Comprehensive MDS, dated [DATE], showed:-Mild cognitive impairment;-Resident had an indwelling catheter related to neurogenic bladder;-He/She required extensive assist with toileting, grooming and hygiene tasks;-Diagnoses included heart disease, high blood pressure, and arthritis. Review of the resident's care plan dated 06/04/26, showed:-He/She required assistance from staff for dressing and transfers;-He/She was dependent on staff to care for urinary catheter;-He/She required EBP for indwelling catheter and wounds. Observation on 06/04/26 at 10:23A.M., showed resident in room, with catheter drainage collection bag, hanging from wheelchair and resting on the floor. There was no signage posted or indication that the resident required EBP when providing cares. Observation on 06/04/26 at 1:43P.M., showed resident in room, with catheter drainage collection bag, hanging from wheelchair and resting directly on the floor. 3.Review of Resident #3's Significant Change MDS, dated [DATE], showed:-Mild cognitive impairment;-Incontinent of bowel and bladder;-Dependent on staff for all transfers, hygiene, eating and bed mobility;-He/She had a Stage II Pressure Injury (open wound, it can look like a scrape, blister, or a shallow crater in the skin; at this stage, some skin may be damaged beyond repair or may die);-Diagnoses included Parkinsons, Non-Alzheimer's dementia and malnutrition. Review of the resident's care plan dated 06/04/26, showed:-He/She able to transfer self to toilet or bed from wheelchair;-He/She needed assist with toileting hygiene;-He/She had a pressure ulcer to the buttocks and right hip;-No interventions or changes implemented specific to the listed ulcers. Observation on 06/04/26 at 1:45P.M., showed signage on resident's door that EBP was indicated for use when caring for resident. Observation on 06/04/26 at 1:49P.M., showed CNA #2 and ADON transferred the resident from wheelchair to bed using a mechanical lift, provided incontinence care utilizing proper technique, ensured resident had all needs met, and then exited room; staff wore protective gloves during cares, did not have on protective isolation gowns. 4.Review of Resident #4's Comprehensive MDS dated [DATE], showed:-No cognitive impairment;-Independent with transfers and mobility;-He/She has a central line for continued IV antibiotics;-Diagnoses included osteomyelitis, high blood pressure and chronic kidney disease. Review of the resident's care plan dated 06/04/26, showed:-He/She was at risk for falls related to gait instability;-He/She was incontinent of bowel;-He/She had chronic wounds to foot and ankle;-No interventions, goals or orders related to long-term antibiotic use, chronic wounds, EBP or central line use and care. Observation on 06/04/26 at 10:00A.M., showed no signage or indication that resident required additional precautions such as EBP. Observation on 06/04/26 at 3:03P.M., showed RN A entered the room to change dressing to central line without applying protective gown. RN A exited and entered resident room several times during observation, and he/she did not apply a gown for any cares provided to resident. During an interview on 06/04/26 at 5:05P.M., CNA #1 said:-EBP is used for any resident with skin breakdown;-EBP means that staff are to thoroughly clean the resident and apply creams and dressings;-A gown is not needed for a transfer of a resident that requires EBP;-When providing care, staff should change gloves and wash hands between dirty and clean tasks;-Wipe away from the urethral opening, either male or female;-Wipe all areas urine had touched;-Urinary collection bag should hang below the bladder and never touch the floor. During an interview on 06/04/26 at 4:43P.M., RN A said:-EBP includes isolation gowns and gloves to prevent infection for residents with a draining wound or tubing of any sort, such as a urinary catheter, central line or colostomy;-A gown is required for transfer of a resident with EBP;-Staff should change gloves and perform hand hygiene between dirty and clean tasks when providing cares to residents;-Staff should dispose of each wipe in the trash after use, not tuck in between resident's legs or in brief;-Wipe away from the urethral opening, either male or female;-Wipe all areas urine had touched;-Urinary catheter tubing should have a dependent loop, no kinks and collection device kept off of the floor. During an interview in 06/04/26 at 4:55P.M., the ADON and Infection Preventionist (IP) said:-EBP is required for residents with wounds, catheters and central lines;-EBP means staff are to wear a gown and gloves with high contact activities;-Residents that require EBP have signage on their doors indicating use of EBP;-EBP (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and guidance should be in each resident's care plan;-Gloves are kept in each resident room and gowns are kept at a centralized location, such as the nurses station;-No gown is required for transfer or incontinence care of an EBP resident, only if manipulating or caring for the device (catheter, central line, wound);-Protective gowns are to be worn during central line dressing changes;-IP provided EBP education at the all staff in-service in May 2026;-Urinary catheter collection bag should not touch the floor, tubing should be kept off the ground and not form a dependent loop as that can cause urinary reflux and increase chance of infection to resident;-Gloves should be removed, hand hygiene performed and new gloves applied when changing from dirty to clean tasks when providing cares to residents;-Hand hygiene could be washing with soap and water or use of Alcohol Based Hand Rub (ABHR). During an interview on 06/04/26 at 5:17P.M., the Director of Nursing said:-EBP residents have signage on their room doors and supplies are kept within line of sight;-Staff are not required to wear a gown when transferring residents, only with care of device that triggered EBP use (emptying catheter, wound care);-Gloves should be removed, hand hygiene performed and new gloves applied when changing from dirty to clean tasks when providing cares to residents;-Wipes should be disposed of after use, not tucked in between resident's legs or inside brief;-Wipe away from the urethral opening, either male or female;-Wipe all areas urine had touched;-Urinary catheter tubing and collection device should never touch the floor. Intakes 3031338 and 3031624