

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265489	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER St Genevieve Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 Ste Genevieve Drive Sainte Genevieve, MO 63670	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>46555</p> <p>Based on observation, interview, and record review, the facility failed to ensure staff provided care for two residents (Resident #7 and #27) out of 14 sampled residents and three residents (Resident #32, #33, and #38) outside the sample, in a manner that maintained their dignity when staff stood while feeding the residents. The facility's census was 53.</p> <p>The facility did not provide a policy.</p> <p>Observation on 11/04/24 at 12:24 P.M. of the dining room showed:</p> <ul style="list-style-type: none"> - Nursing Assistant (NA) B stood over Resident #32 to feed him/her; - Resident #7, #27, #33, and #38 sat together at a separate table; - Certified Nursing Assistant (CNA) A stood over Residents #7 and #27 while assisting them with eating; - CNA A moved back to Resident #27 and stood over him/her while assisting him/her with eating; - CNA A moved back to Resident #27 and stood over the resident to feed him/her; - NA B then joined the table and stood over Resident #7 to feed him/her. - CNA A and NA B then both stood over Residents #38 and #33 to feed them; - NA B then returned to Resident #32's table and stood over him/her to assist with feeding. <p>During an interview on 11/08/24 at 8:30 A.M., CNA A and NA B said when feeding residents, they should be next to them.</p> <p>During an interview on 11/06/24 at 5:30 P.M., the Administrator and Director of Nursing (DON) said staff should sit and be at eye level rather than standing over the residents while feeding them.</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
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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>49754</p> <p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>Based on interview and record review, the facility failed to follow their policy to ensure the Criminal Background Check (CBC), Employee Disqualification List (EDL - a listing of individuals who have been determined to have abused or neglected, misappropriated funds or property from a resident) and the Nurse Aide (NA) Registry were completed prior to the employment start date for two employees out of 10 sampled employees. The facility census was 53.</p> <p>Review of the facility's policy titled, Abuse, Prevention and Prohibition, revised 2021, showed:</p> <ul style="list-style-type: none"> - The facility's abuse prohibition program includes the following seven components: Screening, Training, Prevention, Identification, Investigation, Protection, and Reporting/Response; - All employees will have criminal background checks, state and federal required checks, employment reference checks (previous and current), and license/certification confirmation. <p>Review of the facility's policy titled, Corporate Compliance Process, undated, showed:</p> <ul style="list-style-type: none"> - Criminal background checks are conducted on all potential employees and volunteers in accordance with state and federal laws; - The facility investigates with other licensing and related bodies, including the certified nurse assistant registry and the Employee Disqualification list for the state, to ensure that the prospective employees currently have the licensing or other status required to be employed by the facility. <p>1. Review of Certified Nurse Aide (CNA) D's personnel file showed:</p> <ul style="list-style-type: none"> - Hire date of 06/12/24; - The facility failed to check the CBC, EDL, and NA Registry for CNA D. <p>2. Review of CNA E's personnel file showed:</p> <ul style="list-style-type: none"> - Hire date of 09/21/23; - The facility failed to check the CBC, EDL, and NA Registry for CNA E. <p>During an interview on 10/06/24 at 11:55 A.M., the Human Resource/Payroll Manager said that after employees are interviewed, he/she completes the Family Care Safety Registry (FCSR), CBC, EDL, and NA registry checks, then he/she files the forms in his/her cabinet. He/she does not use a checklist to ensure everything gets done but will start implementing one. He/she knows that he/she completed all of the checks for CNA D and CNA E, but can't seem to find them anywhere. The HR Manager said he/she had done all of background checks on the two employees that have nothing filled out on the form. He/She couldn't provide any proof that he/she did the background checks because he/she had misplaced both of the folders that contained that information, for both of those employees.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/06/24 at 5:30 P.M., the Administrator, Director of Nursing (DON), and Human Resource/Payroll Manger all said they would expect the FCSR, CBC, EDL, and Nurse Aide Registry to be completed on all new hires prior to their start date.</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>39360</p> <p>Based on observation, interview, and record review, the facility failed to maintain an error rate of less than five percent (%) when medications were given. There were 28 opportunities with two errors made, for an error rate of 7.14%. This affected one resident (Resident #13) out of 14 sampled residents. The facility census was 53.</p> <p>The facility did not provide a policy related to insulin administration.</p> <p>Review of Humalog Kwik Pen directions, revised July 2023, showed:</p> <ul style="list-style-type: none"> - Pull the pen cap straight off; - Check the liquid in the pen; - Select a new needle; - Push the capped needle straight onto pen and twist the needle on until it is tight; - Priming the pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly; - To prime pen, turn the dose knob to select two units; - Hold pen with needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top; - Push the dose knob in until it stops and 0 is seen in the dose window; - Insulin should be seen at the tip of the needle, if none is seen, repeat priming steps; - Turn dose knob to select unit amount needed; - Always check number dose in window; - Insert needle into skin and hold 5 seconds, if a 0 can be seen in dose window, you have received amount dialed. <p>1. Review of Resident #13's medical record showed:</p> <ul style="list-style-type: none"> - Diagnoses of Type II Diabetes Mellitus (a condition in which the body has trouble controlling blood sugar and using it for energy); - An order, dated 11/02/24, for Humalog (insulin) Kwik Pen, to be given according to sliding scale. <p>Observation on 11/06/24 at 11:35 A.M. showed:</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Licensed Practical Nurse (LPN) F obtained blood glucose check for Resident #13;</p> <p>- Ordered amount of insulin to be given was three units;</p> <p>- LPN F failed to prime the insulin pen with two units prior to dosing and administering insulin.</p> <p>During an interview on 11/06/24 at 11:36 A.M., LPN F said he/she should have wasted two units before giving the dose, but didn't.</p> <p>Observation on 11/06/24 at 3:54 P.M. showed:</p> <p>- LPN F obtained glucose check for Resident #13;</p> <p>- Ordered amount of insulin to be given was six units;</p> <p>- LPN F failed to prime the insulin pen with two units prior to dosing and administering insulin.</p> <p>During an interview on 11/06/24 at 3:55 P.M., LPN F said he/she would have normally primed the insulin pen, but had forgotten again.</p> <p>During an interview on 11/06/24 at 5:30 P.M., the Administrator and Director of Nursing (DON) said they would expect insulin pens to be primed per the manufacturer's instructions for use.</p> <p>46460</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46555</p> <p>Based on observation, interview, and record review, the facility staff failed to follow appropriate infection control practices while assisting two residents (Resident #7 and #27) out of 14 sampled residents and three residents outside the sample (Resident #32, #33 and #38) with their lunch meal. The facility failed to store and distribute food under sanitary conditions, increasing the risk of cross-contamination and food-borne illness. These practices had the potential to affect all residents who are served food from the kitchen. The facility's census was 53.</p> <p>Review of the facility's policy titled, Dietary Policies, undated, showed:</p> <ul style="list-style-type: none"> - Develop and maintains dietary services polices and procedures; - Assists with infection control and safety policies; - Ensures objectives and philosophy are understood and maintained by dietary staff; - Alerts administrator of existing or potential problem areas; - Ensures sanitary environment for food preparation and proper cleansing of equipment; - Ensure proper storage of foods to protect it from contamination. <p>Review of the facility's policy titled, Food Storage, revised [DATE], showed:</p> <ul style="list-style-type: none"> - If storage units are provided in community areas, those units shall be equipped with thermometers, shall hold foods which are sealed, labeled and dated; - Units shall be routinely monitored to maintain sanitary units and to discard expired food. <p>Review of the facility's policy, Hand Hygiene, dated 2019, showed:</p> <ul style="list-style-type: none"> - Appropriate hand hygiene is essential in preventing transmission of infectious agents; - Purpose is to cleanse hands to prevent the spread of potentially deadly infections and to provide a clean and healthy environment for residents, staff, and visitors; - Hand hygiene continues to be the primary means of preventing the transmission of infection: - Antimicrobial gel (hand hygiene that does not require water) cannot be used in place of proper hand washing techniques in a food service setting. <p>1. Observation on [DATE] at 12:24 P.M. of the dining room showed:</p> <ul style="list-style-type: none"> - Residents #7, #27, #33, and #38 sat together at a table; <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - Certified Nursing Assistant (CNA) A did not sanitize his/her hands before feeding Resident #7; - CNA A, without sanitizing hands, held his/her hand over Resident #38's hand on the utensil to assist him/her with eating; - CNA A did not sanitize his/her hands before he/she held his/her hand over Resident #33's hand on the utensil to assist him/her with eating; - CNA A assisted Resident #7 by holding his/her hand over the resident's hand to feed him/her, then moved to assist Resident #27 and did not sanitize his/her hands; - After assisting Resident #32 at another table, Nursing Assistant (NA) B fed Resident #7 without sanitizing his/her hands; - CNA A and NA B then assisted Residents #38 and #33 without sanitizing their hands at any time; - NA B then reached over Resident #33 and his/her plate, and touched the rim of the resident's cup with a bare hand to give the resident a drink; - NA B moved back to Resident #32's table to assist him/her with eating without sanitizing hands. <p>During an interview on [DATE] at 5:30 P.M., the Administrator and Director of Nursing (DON) said they would expect staff to sanitize hands between serving or assisting residents to eat.</p> <p>During an interview on [DATE] at 8:30 A.M., NA B said staff should sanitize their hands when delivering trays from the kitchen to the residents and when picking things up off the floor. When asked about sanitizing hands between assisting residents, CNA A said yes, they were thinking that.</p> <p>2. Observation on [DATE] at 3:51 P.M. of the dry food storage room showed:</p> <ul style="list-style-type: none"> - Two unopened clear bags of chips, unlabeled and undated; - One opened clear bag of chips, unlabeled and undated; - One opened taco seasoning packet in a plastic storage bag, undated; - One opened bag of cake mix, undated. <p>3. Observation on [DATE] at 3:51 P.M. of the double door fridge showed:</p> <ul style="list-style-type: none"> - A quart-size plastic storage bag of apple slices, unlabeled and undated. <p>4. Observation on [DATE] at 3:51 P.M. of the walk-in refrigerator showed:</p> <ul style="list-style-type: none"> - A plate of prepared salad, covered with plastic wrap, unlabeled and undated; - Two one-gallon size plastic storage bags containing sliced cheese, unlabeled and undated; <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- A quart size plastic storage bag of deli meat, unlabeled and undated;</p> <p>- A gallon size plastic storage bag of boiled eggs, unlabeled and undated;</p> <p>- A gallon size plastic storage bag with a half head of iceberg lettuce, unlabeled and undated.</p> <p>5. Observation on [DATE] at 3:51 P.M. of the walk-in freezer showed:</p> <p>- Six bags of frozen meat, unlabeled and undated;</p> <p>- Ice buildup approximately 2 inch by 1 inch in size on the bottom of the freezer doorstep and the bottom side edge of the door.</p> <p>6. Observation on [DATE] at 11:13 P.M. of the kitchen staff preparing food showed:</p> <p>- The Dietary Manager (DM) laid the thermometer on the table and did not sanitize it before temperature testing meatloaf, burger patties, and pureed food;</p> <p>- Dietary Aide C put on gloves, assembled the blender, picked up a pan of burger patties and dumped them into the blender. He/She struggled to get the patties down into the blender to put the lid on and touched the burgers, wearing the same gloves, while trying to get the patties pushed down into the blender.</p> <p>During an interview on [DATE] at 3:20 P.M., Dietary Aide C said he/she should change gloves between dirty to clean and touching food items.</p> <p>Review of the food temperature logs, dated [DATE] through [DATE], showed:</p> <p>- Temperatures were taken on [DATE]st for 30 out of 31 missed opportunities;</p> <p>- Temperatures were taken [DATE]st through the 7th for 24 out of 31 opportunities missed;</p> <p>- Temperatures were taken [DATE]rd, 24th, 29th, and 30th for 26 out of 30 opportunities missed.</p> <p>During an interview on [DATE] at 10:30 A.M., the DM said he/she would be responsible for completing temperature logs for the refrigerators, freezer, and dishwasher and was unable to provide any logs. The cook temperature tests the food each meal and provided logs to review.</p> <p>6. Observation on [DATE] at 2:00 P.M. of the 400 hall unit refrigerator showed:</p> <p>- A temperature of 46 degrees;</p> <p>- An opened container of apple juice with no name or date on it;</p> <p>- An opened container of cranberry juice with no name or date on it;</p> <p>- An unopened bottle of pressed juice with no name on it.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 2:00 P.M., Certified Medication Technician (CMT) H said he/she did not think there was a temperature log, but there probably should be one. The apple juice belonged to a resident that is no longer at the facility and should not be in there. He/she dumped the apple juice in the sink and discarded the bottle.</p> <p>7. Observation on [DATE] at 2:15 P.M. of the 100 hall unit refrigerator showed a temperature of 46 degrees.</p> <p>During an interview on [DATE] at 2:15 P.M., CMT I said night shift is responsible for completing the temperature logs and provided the log book containing logs for both unit refrigerators.</p> <p>Review of the unit refrigerator temperature log books, dated August through [DATE], showed:</p> <ul style="list-style-type: none"> - [DATE] - 400 unit - 2 days missed with 21 of the completed days having a temperature over 41 degrees; - [DATE] - 100 unit - 2 days missed with 4 of the completed days having a temperature over 41 degrees; - [DATE] - 400 unit - 18 days missed with 7 of the completed days having a temperature over 41 degrees; - [DATE] - 100 unit - 2 days missed with 7 of the completed days having a temperature over 41 degrees; - [DATE] - 400 unit - 1 day missed with 22 of the completed days having a temperature over 41 degrees; - [DATE] - 100 unit - 1 day missed with 25 of the completed days having a temperature over 41 degrees. <p>During an interview on [DATE] at 3:15 P.M., the DM said he/she would expect staff to change gloves between touching surfaces or appliances and touching food, would expect all temperature logs to be completed per regulation, food to be dated and labeled, and the thermometer to be sanitized after it was sitting on the counter prior to testing the food.</p> <p>During an interview on [DATE] at 5:30 P.M., the Administrator and Director of Nursing (DON) said they would expect staff to change gloves between touching surfaces or appliances and touching food, would expect all temperature logs to be completed per regulation, food to be dated and labeled, and the thermometer to be sanitized after it was sitting on the counter prior to testing the food.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>39360</p> <p>Based on observation, interview, and record review, the facility failed to maintain appropriate infection control practices for two residents (Resident #13 and #41) out of 14 sampled residents and one resident (Resident #14) outside the sample when facility staff did not perform hand hygiene between finger stick blood sugar (FSBS) checks and insulin (a hormone that lowers the level of glucose (a type of sugar) in the blood) administration and failed to disinfect the glucometer (a machine used to measure blood sugar) per the manufacturer's recommendations. The facility's census was 53.</p> <p>Review of the facility's policy titled, Cleaning and Disinfecting Blood Glucose Meters, dated 2019, showed;</p> <ul style="list-style-type: none"> - Apply gloves before performing a blood glucose test. Glucose monitoring, administration of insulin, and any other procedure that involves potential exposure to bodily fluids; - Remove gloves and perform hand hygiene; - Apply new gloves; - Thoroughly clean all visible soil or organic material (e.g. blood) from glucometer before disinfection; - Perform hand hygiene (i.e. hand washing with soap and water or use of an alcohol-based hand rub) immediately after removal of gloves and before touching other medical supplies intended for use on other residents; - Follow manufacturer's guidelines for cleaning and disinfecting of glucose meters. Specific guidelines for glucose meters may vary with the manufacturer; - Use of disinfectants, antiseptics, and germicides are by manufacturers' instructions and Environmental Protection Agency (EPA) or Food and Drug Administration (FDA) label specifications to avoid harm to staff, residents, and visitors and to ensure effectiveness. All nursing staff is trained in the proper procedure, protective equipment required (if any), and safety precautions. <p>Review of the cleaning and disinfecting instructions for the glucometer showed:</p> <ul style="list-style-type: none"> - Meter should be cleaned and disinfected after every use on each patient; - Validated cleaning wipes include Sani-Cloth Germicidal Disposable Wipes; - Read instructions provided by manufacturer of Super Sani-Cloth Germicidal Disposable Wipes before using. <p>Review of the Guidelines for Super Sani-Cloth Disposable Wipes showed:</p> <ul style="list-style-type: none"> - Always dispense wipe through lid; <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - Remove wipe away from face and eyes and keep lid closed; - Unfold clean wipe and thoroughly wet surface; - Allow treated surface to remain wet for two minutes then let air dry; - Do not reuse towelette and dispose of in trash. <p>Review of the facility's policy titled, Hand Hygiene, dated 2019, showed:</p> <ul style="list-style-type: none"> - Appropriate hand hygiene is essential in preventing transmission of infectious agents; - Purpose is to cleanse hands to prevent the spread of potentially deadly infections and to provide a clean and healthy environment for residents, staff, and visitors; - Hand hygiene continues to be the primary means of preventing the transmission of infection: - Antimicrobial gel (hand hygiene that does not require water) cannot be used in place of proper hand washing techniques in a food service setting; - Staff must perform hand hygiene even if gloves are utilized; - Gloves or the use of baby wipes are not a substitute for hand hygiene; - Alcohol antiseptic hand rub is appropriate for routine hand hygiene in most clinical situations; - Hand antiseptics using an alcohol antiseptic or antimicrobial soap is indicated when caring for high-risk resident populations, before performing invasive procedures, after caring for residents with infected wounds, and when caring for residents who are infected with resident organisms. <p>Review of the facility's policy titled, Gloves, dated 2019, showed:</p> <ul style="list-style-type: none"> - Purpose is to prevent healthcare worker exposure to blood and other potentially infectious materials from the resident, equipment, and the environment; - Disposable single-use examination gloves are worn when hand contact with blood, other potentially infectious materials, mucous membranes and non-intact skin is anticipated, and handling or touching contaminated items or surfaces; - Sterile gloves and examination gloves are removed as soon as practical when contaminated, between resident contacts, and before touching uncontaminated surfaces or other areas of the same resident's body that may be uncontaminated. <p>1. Observation on 11/06/24 at 11:34 A.M. of Resident #14 and Resident #41's fingerstick blood sugar (FSBS) showed:</p> <ul style="list-style-type: none"> - Registered Nurse (RN) G pushed the cart to Resident #14's door and, without sanitizing hands, donned gloves; <p>(continued on next page)</p>		

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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 - Few</p>	<ul style="list-style-type: none"> - RN G obtained a sani-cloth from its container and wiped the top of the med cart; - RN G obtained a glucometer from a supply caddy on top of the cart, wiped the glucometer with the sani-cloth for a few seconds and laid it on top of the wet cart; - RN G removed gloves, did not sanitize hands, donned new gloves and, after approximately 45 seconds while gathering supplies from the caddy, picked up the glucometer from the top of the cart; - RN G walked into Resident #14's room, performed FSBS, and returned to the cart in the hall and disposed of supplies in the trash bin on the side of the cart; - RN G obtained a new sani-cloth from its container and wiped the glucometer with the sani-cloth for a few seconds and put the glucometer back in a caddy on top of the cart that contained supplies, then pushed the cart to Resident #41's doorway for FSBS; - RN G sanitized hands and donned new gloves; - RN G obtained a sani-cloth from its container, picked up the supply caddy from the top of the cart and wiped off the top of the cart for a few seconds with a sani cloth and set the caddy back down on it without wiping the bottom of the caddy; - RN G obtained the glucometer from the caddy, wiped it with a sani-cloth for a few seconds, and set it back on top of the wet cart; - RN G threw away the sani-cloth and gloves in the trash bin on the side of the cart and donned new gloves without performing hand hygiene; - RN G gathered supplies from the caddy, walked into Resident #41's room and obtained FSBS; - RN G removed gloves in the resident's room, threw trash away, and sanitized hands. <p>2. Observation on 11/06/24 at 11:35 A.M. showed:</p> <ul style="list-style-type: none"> - Licensed Practical Nurse (LPN) F donned gloves without sanitizing hands and obtained a FSBS from Resident #13; - LPN F held the glucometer in one hand, walked to medication cart, set the glucometer on the cart and with the same gloves, picked up the insulin pen from a container sitting on top of the cart and needle was placed; - With the same soiled gloves, LPN F administered insulin to Resident #13, then removed gloves; - LPN F returned to the cart and wiped the glucometer with a sani cloth for approximately five to six seconds, then placed on top of the cart to dry; - Three minute timer was started. <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/06/24 at 11:36 A.M., LPN F said he/she wipes the glucometer off and allows it to dry for two minutes, then it would be ready for the next use.</p> <p>3. Observation on 11/06/24 at 3:54 P.M. showed:</p> <ul style="list-style-type: none"> - LPN F sanitized hands, donned gloves and obtained FSBS from Resident #13; - LPN F returned to the cart and with the same gloves, cleaned insulin pen with alcohol pad, placed needle, and turned dial to ordered dose of insulin; - With the same soiled gloves, LPN F administered insulin to Resident #13 and removed gloves; - LPN F returned to the cart, sanitized hands, cleaned the glucometer with sani wipes for approximately five to six seconds and placed on the cart to allow to dry; - Three minute timer started. <p>During an interview on 11/06/24 at 4:09 P.M., LPN F said he/she should have changed gloves when going from dirty to clean, after obtaining blood glucose check and before administering the insulin. LPN F said he/she thought the disinfectant was bleach and didn't know the glucometer was to stay wet for two minutes but had thought it was supposed to dry for two minutes.</p> <p>4. Observation on 11/06/24 at 4:08 P.M. of Resident #14's FSBS showed:</p> <ul style="list-style-type: none"> - RN G sanitized hands and donned gloves; - RN G obtained a sani-cloth from its container and wiped the glucometer for about 10 seconds, laid the glucometer on top of the unsanitized cart, and disposed of the sani-cloth in the trash bin on the side of the cart; - RN G gathered supplies from the caddy on top of the cart, walked into Resident #14's room and obtained FSBS; - RN G obtained a sani-cloth from its container and wiped glucometer for about ten seconds and set on top of the unsanitized cart; - RN G administered Novolog insulin without performing hand hygiene and changing gloves between FSBS and insulin administration; - RN G removed gloves, sanitized hands, and donned new gloves; - RN G administered Humulin 70/30 insulin, then returned to the cart, obtained a sani-cloth from its container, wiped the insulin pen with the sani-cloth for a few seconds, and put the pen in the caddy on top of the cart; - RN G put the glucometer from the unsanitized top of the cart into the supply caddy, wiped off the top of the cart, removed gloves and sanitized hands. <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/06/24 at 4:27 P.M., RN G said he/she should have sanitized and changed gloves after FSBS and before giving insulin. He/She is not sure how long to leave items wet after cleaning with a sani-cloth and is not sure what the kill time is for sani-cloths. He/She then looked at a sani-cloth container on the cart and said he/she should have left it in contact for two minutes and that it clearly says that on the container.</p> <p>During an interview on 11/06/24 at 5:30 P.M., the Administrator and Director of Nursing (DON) said they would expect staff to change gloves when going from dirty to clean, ensure hands were sanitized after providing care, and glucometers are to be cleaned after each use per manufacturer's recommendations.</p> <p>46460</p>