

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 03/26/2026
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)		
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review, the facility failed to provide a Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN: Medicare requires SNFs to issue a SNF ABN to beneficiaries prior to providing care that Medicare usually covers, but may not pay for because the care is not medically reasonable and necessary or considered custodial) to two residents (Residents #31 and #44) out of two sampled residents who were discharged from Medicare Part A services with benefit days remaining and continued to reside in the facility. The facility's census was 57. Review of the Form Instructions: Advance Beneficiary Notice of Non-coverage, undated, showed:- When Medicare is not likely to cover a specific item or service, healthcare providers and suppliers must use this ABN to let the patient know they may be financially liable before they get the items or services;- Notifiers must deliver the ABN to the patient or their representative before providing the items or services; review the ABN with the patient or their representative and answer any questions before it's signed; deliver the ABN far enough in advance that the patient or representative has time to consider the options and make an informed choice; give a copy to the patient or representative, if requested, once all blanks are completed and the form is signed; and retain a copy of the completed, signed ABN on file.1. Review of Resident #31's medical record showed:- The resident discharged from Medicare Part A services on 03/12/26;- The resident remained in the facility;- The facility failed to issue a SNF ABN to the resident.2. Review of Resident #44's medical record showed:- The resident discharged from Medicare Part A services on 11/17/25;- The resident remained in the facility;- The facility failed to issue a SNF ABN to the resident. During an interview on 03/25/26 at 1:08 P.M., the Administrator in Training said the previous Business Office Manager (BOM) hadn't been doing SNF ABNs for the residents who remained in the facility after the end of their Medicare Part A stay. During an interview on 03/26/26 at 12:15 P.M., the Administrator, Administrator in Training, and Regional BOM said they would expect a SNF ABN to be issued when a resident's Medicare Part A stay ended and the resident remained in the facility.		

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the resident and/or the resident's representative in writing of a transfer to the hospital and failed to provide a copy of the bed hold policy upon transfer to the hospital for four residents (Residents #8, #13, #40, and #44) out of four sampled residents. The facility also failed to notify the ombudsman (a trained advocate who investigates and resolves complaints made by or on behalf of residents in nursing homes, assisted living, and other residential care facilities) of the transfers. The facility's census was 57. Review of the facility's Bed Hold Policy and Agreement Form, revised February 2014, showed:- The purpose is to establish policy and procedure for the facility to notify the resident/responsible party of the Bed Hold Policy and Agreement To Pay Charges For Bed Hold. The facility is to execute an acknowledgement stating whether or not such resident desires to exercise his or her right to a bed hold. The policy should meet applicable regulatory, federal, and state program guidelines;- It is the policy of the Management Company that the facility will establish a system to notify the resident/responsible party/resident representative of the facility bed hold policy;- The Bed Hold Agreement is to be obtained for each occurrence - hospital or therapeutic home leave. The policies provided by the facility did not address written notification upon transfer to the hospital. 1. Review of Resident #8's medical record showed:- admission date of 12/28/23;- Transferred to the hospital on [DATE] and returned to the facility on [DATE];- No documentation that written notification of the transfer or a copy of the bed hold policy was provided to the resident and/or the resident's representative;- Transferred to the hospital on [DATE] and returned to the facility on [DATE];- No documentation that a copy of the bed hold policy was given to the resident and/or the resident's representative;- No evidence that notification of transfers was provided to the ombudsman. 2. Review of Resident #13's medical record showed:- admission date of 07/24/23;- Transferred to the hospital on [DATE] and returned to the facility on [DATE];- No documentation that written notification of the transfer or a copy of the bed hold policy was provided to the resident and/or the resident's representative;- - Transferred to the hospital on [DATE] and returned to the facility on [DATE];- No documentation that a bed hold policy was given to the resident and/or resident's representative;- No evidence that notification of transfers was provided to the ombudsman. 3. Review of Resident #40's medical record showed:- admission date of 01/27/26;- Transferred to the hospital on [DATE] and returned to the facility on [DATE];- No documentation that written notification of the transfer or a copy of the bed hold policy was provided to the resident and/or the resident's representative;- No evidence that notification of transfers was provided to the ombudsman. 4. Review of Resident #44's medical record showed:- admission date of 09/30/25;- Transferred to the hospital on [DATE] and returned to the facility on [DATE];- No documentation that written notification of the transfer or a copy of the bed hold policy was provided to the resident and/or the resident's representative;- No evidence that notification of transfers was provided to the ombudsman. During an interview on 03/17/26 at 2:42 P.M., the Ombudsman said the facility had not been submitting their transfers and discharges. During an interview on 03/24/26 at 2:20 P.M., the Administrator in Training said she was unsure if information was being sent to ombudsman regarding transfers and discharges. The Business Office Manager (BOM) was terminated, and she believed it probably wasn't done. She was seeing where some transfer/bed hold information was missing. During an interview on 03/26/26 at 12:15 P.M., the Administrator, Administrator in Training, and Regional BOM said they would expect a written notification of transfer and a copy of the bed hold to be given to the resident and/or their representative and for notification of transfers to be sent to the ombudsman.		

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review, the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) program met at least quarterly, as evidenced by a lack of documented QAPI meetings over an extended period. This had the potential to affect all residents by limiting the facility's ability to identify and address quality of care and safety concerns. The facility census was 57. The policy provided by the facility did not address quarterly QAPI meetings. Review of QAPI meeting documentation, provided by the Administrator in Training, showed:- A QAPI meeting was held on January 21, 2025; - A QAPI meeting was held on April 22, 2025;- A QAPI meeting was held on May 20, 2025;- A QAPI meeting was held on February 10, 2026;- No documentation of QAPI meetings conducted between May 20, 2025, and February 10, 2026 (approximately eight months); - No documentation the QAPI program was implemented on a consistent and ongoing basis during this time period. During an interview on 03/26/26 at 12:15 P.M., the Administrator, Administrator in Training, and Regional Business Office Manager said they would expect QAPI meetings to be held on a regular basis, at least quarterly, and to include appropriate members of the interdisciplinary team.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to maintain proper infection control practices during catheter (a flexible tube inserted into the bladder to drain urine) care for one resident (Resident #3) out of one sampled resident with a catheter and during wound care for one resident (Resident #33) out of one sampled resident with a wound. The facility's census was 57. Review of the facility's policy titled, Catheter Care, undated, showed: - Wash hands, gather equipment, and take to bedside; - Explain procedure to resident and screen for privacy; - Position resident; - Put on gloves; - Wash perineum (genital area) well with soap and warm water or peri-wipes, taking care to wash from front to back; - Clean area at catheter insertion site well, taking care not to pull on catheter or advance further; - All debris must be removed from catheter at insertion site; - Discard disposable equipment properly; - Position resident comfortably with call light in reach; - Wash hands. Review of the facility's policy titled, Enhanced Barrier Precautions, revised 12/12/23, showed: - It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms (MDRO &ndash; microorganisms that are resistant to one or more classes of antimicrobial agents); - Enhanced barrier precautions refer to the use of gown and gloves during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices); - All staff receive training on enhanced barrier precautions upon hire and at least annually and are expected to comply with all designated precautions; - An order for enhanced barrier precautions will be obtained for residents with any of the following: wounds and/or indwelling medical devices (e.g., urinary catheters) even if the resident is not known to be infected or colonized with a MDRO; - The Infection Preventionist will incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education; (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- High-contact resident care activities include wound care: any skin opening requiring a dressing; - Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until the wound heals or the indwelling medical device is removed. 1. Observation on 03/26/26 at 10:10 A.M., of Resident #33's wound care showed: - Licensed Practical Nurse (LPN) A pushed the treatment cart down the hall to the resident's doorway and, without performing hand hygiene, obtained wound cleanser, a sleeve of four-inch square gauze, and scissors from the treatment cart and placed them on the resident's night stand without a barrier; - LPN A washed hands, put on gloves, and did not put on a gown; - LPN A removed the resident's heel protector boot and sock, obtained the scissors from the nightstand, cut off the old dressing, placed the soiled scissors back on the nightstand, and threw the old dressing in the trash; - LPN A obtained the wound cleanser from the nightstand, sprayed a gauze 4x4, threw it away and said, I should have changed my gloves; - LPN A removed gloves, sanitized hands, and put on new gloves; - LPN A cut Aquacel (wound drainage absorbent product) with the same soiled scissors and applied it to the wound on the resident's heel and wrapped the resident's foot and ankle with Kerlix (gauze bandage roll); - LPN A dropped the scissors on the floor while cutting the tape to secure the Kerlix, picked them up and used them to finish cutting the tape, and secured the tape to the Kerlix; - LPN A put an ACE wrap (an elastic bandage used to provide compression and reduced swelling for injuries) on the resident's foot and lower leg, then put the resident's heel protector boot on; - LPN A removed gloves, washed hands, put on new gloves, put a piece of Aquacel back into the original package and placed it in a box with the patient-specific wound supplies in the resident's wardrobe; - LPN A removed the trash bag from the resident's room, threw the trash and gloves away in a trash container in the hall, obtained a new trash bag from staff in the hall and put the new bag in the resident's trash can with his/her bare hands and touched the sides of the can; - LPN A put the wound cleanser, sleeve of gauze, and scissors back in the treatment cart with his/her bare hands and pushed the resident down the hall in his/her wheelchair. During an interview on 03/26/26 at 10:30 A.M., LPN A said he/she would wear a gown with wounds that were open, oozing, or have methicillin-resistant staphylococcus aureus (MRSA - a type of bacteria that can be resistant to several antibiotics). He/She should have worn a gown. He/She should perform hand hygiene before care, when going from dirty to clean care, and after care. He/She should change gloves when going from dirty to clean care or when they got a hole. He/She should clean the scissors between residents. He/She should clean the scissors before using them, when dropping (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	them, and after a dirty task. He/She didn't know when to use a barrier because he/she didn't use a barrier. He/She didn't know when to clean supplies that were used by more than one resident. He/She just started following the wound nurse around and had been taking wound measurements. 2. Observation on 03/26/26 at 10:45 A.M., of Resident #3's catheter care showed: - Certified Nursing Aide (CNA) B sanitized hands, obtained a clean basin of soapy water, put on a gown, gloves, and mask, and placed clean towels and the basin of soapy water on the resident's bedside table with a barrier; - CNA B placed a gait belt around the resident and assisted him/her to bed; - CNA B pushed the wheelchair away, hung the resident's catheter on the side of the bed, removed the gait belt, pulled the resident's pants down, and removed the resident's brief; - With the same gloves, CNA B placed a clean cloth into the basin, wrung it out, cleaned the perineal area down each side and placed the cloth into a trash bag; - With the same gloves, CNA B placed a second clean cloth into the basin, wrung it out, cleaned across the resident's abdomen, down both sides again and placed the cloth into the trash bag; - With the same gloves, CNA B placed a third clean cloth into the basin, wrung it out, cleaned down the catheter tubing three to five inches and placed the cloth into the trash bag; - With the same gloves, CNA B opened the resident's bathroom door to wet a clean cloth with fresh water; - With the same gloves, CNA B cleaned the resident's peri area with the cloth and placed it into the trash bag; - With the same gloves, CNA B opened the cabinet, obtained a new brief and removed the resident's shoes; - CNA B removed gloves, sanitized hands, and put on clean gloves; - CNA B placed the brief, pants, and shoes on the resident, then assisted the resident to sit up on the side of the bed; - CNA B placed a gait belt around the resident, assisted him/her back to the wheelchair, placed the foot pedals on the wheelchair, and placed the catheter into a bag; - CNA B removed the gown, gloves, mask, and washed his/her hands; - CNA B took the linens, placed in hall the hamper and sanitized his/her hands in the hall. During an interview on 03/26/26 at 11:02 A.M., CNA B said he/she should have sanitized and changed gloves after removal of the brief and before starting catheter care. He/She should not have touched the bathroom doorknob and cabinets with dirty gloves and should have sanitized his/her hands and put on clean gloves prior to completing care again. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/26/26 at 12:15 P.M., the Administrator, Administrator in Training, and Infection Preventionist said they would expect staff to wear a gown when completing wound care, to change gloves between dirty and clean care, to not touch items/objects in the resident's room with dirty gloves, to sanitize scissors if dropped and before and after use, a barrier to be used for supplies when conducting wound care, and to sanitize supplies that were used for other residents after wound care and before returning to the treatment cart.		