| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265509 | A. Building<br>B. Wing | 03/27/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| South County Health Care Center | 1101 West Outer 21 Road<br>Arnold, MO 63010 |

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

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect three residents (Residents #1, #2, and #3) of three sampled residents from sexual abuse when the Assistant Director of Nurses (ADON) offered and provided his/her personal medications to the residents in exchange for sexual activity and inappropriate touching. The facility also failed to protect Resident #1, with a history of substance abuse, from abuse when the Activities Director (AD) took the resident in his/her personal vehicle to purchase marijuana. The AD and resident then used the marijuana together while in the vehicle. The facility census was 86. The administration was notified on 3/25/26 at 1:30 P.M. and 3/26/26 at 1:00 P.M. of the Immediate Jeopardy situations which began on 03/18/26. The IJ was removed on 3/26/26, as confirmed by surveyor onsite verification. Review of the facility's Abuse and Neglect Policy dated 06/12/24, showed:- Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations;- It includes verbal abuse, sexual abuse, physical abuse, and mental abuse;- Sexual abuse can include rape, sodomy, and coerced nudity. Review of the facility's investigation dated 03/18/26, showed:- The ADON informed the Administrator (ADM) Resident #1 was purchasing marijuana from staff member, AD and an investigation was started;- As the investigation was on-going, Resident #1 was observed to be smoking marijuana outside in the yard at the facility;- The ADM searched the resident's room and found marijuana and a bottle of Xanax (a benzodiazepine drug used to treat anxiety) 0.5 milligram (mg) that contained 28 pills, that belonged to the ADON;- The ADON was questioned and said Resident #1 had taken them from his/her purse while he/she was on duty;- The ADM questioned Resident #1 about the drugs found in his/her room. Resident #1 said the ADON gave him/her the Xanax in exchange for sexual favors. Resident #1 said the ADON gave two other residents drugs also;- Resident #1 provided multiple pages of text messages between him/her and the ADON in which they discussed sexual activity and the ADON providing Xanax to the resident;- The Administrator was told Resident #2 and #3 had also received Xanax;- Resident #2 confirmed the ADON had provided him/her with Xanax and touched the resident inappropriately;- Resident #3 told the Administrator the ADON had provided him/her, two Xanax and the ADON fondled his/her genitalia;- A statement from housekeeper (HK) A showed he/she was not aware of the relationship with the ADON but had witnessed Resident #1 and the AD riding in a vehicle together and consuming marijuana. Review of the facility's On-Board Training, completed on hire, showed:All policies are delivered and signed prior or on start date with all new hires. The policies provided include but are not limited to: Social Media Policy, Possession of Prescribed and Over the Counter Medications while on Duty, Behavioral Emergency Policy, Sexual Harassment, Abuse and Neglect, Elder Abuse Reporting:- The ADON signed and dated the above policies on 03/13/26;- HK A signed and dated the above policies on 11/26/25;- CNA B signed and dated the above policies on 11/20/25;- AD signed and dated the above policies on 04/24/25. Review of Resident #1's Pre-admission Screening and Resident Review (PASRR- federally mandated screening process for individuals with serious mental illness (SMI), intellectual<br>(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 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | disability/developmental disability (IDD/DD), and/or related condition), dated 08/30/22 showed:- The resident has a history of aggression, manipulative behavior, and sexually inappropriate behavior.- The resident has a diagnosis of a closed head injury due to a motor vehicle accident.- The resident has a history of using and abusing multiple substances including opioids, benzodiazepines (a class of central nervous system (CNS) depressant), alcohol, stimulants and amphetamines (a CNS stimulant).- Alcohol and substance abuse began at age [AGE].- The resident has a history of requesting Xanax (a benzodiazepine) and Adderall (combination of amphetamine and dextroamphetamine).- The resident is mildly intellectually disabled (MID - an Intelligence Quotient of 50-70). Review of Resident #1's Quarterly Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by the facility staff, dated 02/4/26 showed:- admission date of 12/27/25;- Cognitively intact;- Required supervision with activities of daily living (ADLs);- Had a legal guardian. Review of Resident #1's Physician Order Sheet (POS) dated March 2026, showed:- Diagnoses of Personality Disorder (a mental health disease causing difficulties with relationships), MID, opioid dependency, and Bi-Polar Disorder with Psychotic features (severe form of mental disease-causing mania and depression and hallucinations and delusions);- No order for Xanax. Review of Resident #2's PASRR dated 05/07/21, showed:- The resident had a history of substance abuse;- Has very disorganized thinking and flight of ideas;- Has delusions and paranoia. Review of Resident #2's Quarterly MDS dated [DATE], showed:- admission date of 07/30/25;- Had some cognitive impairment;-Required supervision with daily ADLs. Review of Resident #2's POS dated March 2026, showed:- Diagnoses of depression and mania, schizoaffective disorder (chronic mental health condition marked by hallucinations and delusions);- No order for Xanax. Review of Resident #3's Quarterly MDS dated [DATE], showed:- admission date of 01/27/26;- Cognitively intact;- Required substantial assistance with ADLs. Review of Resident #3's POS dated March 2026, showed:- Diagnoses of Personality Disorder, substance abuse, depression, Schizophrenia, and paraplegia (loss of motor function in the lower half of the body);- No order for Xanax. During an interview on 03/23/26 at 11:00 A.M., the ADM said on 03/18/26 the ADON told him Resident #1 told him/her he/she purchased marijuana from staff members AD and certified nurse aide (CNA) A. The ADON told the ADM the information had been provided by Resident #1. Later that day, the ADM was informed by the Assistant Maintenance (AM), Resident #1 had been outside smoking marijuana. The ADM said he completed a contraband search of Resident #1's room and found marijuana and a bottle of Xanax 0.5 milligram (mg) prescribed to the ADON. He said the ADON told him the resident had taken them from his/her purse. During the investigation, Resident #1 said the ADON had given the Xanax to him/her and two other residents. Resident #1 showed the ADM text messages from the ADON to Resident #1. The texts were sexually explicit in content and showed conversation regarding the ADON providing money for the resident to purchase marijuana from unknown staff. The ADM said the ADON was suspended pending the investigation. He had not been aware of this relationship. During an interview on 03/23/26 at 11:40 A.M., Resident #1 said he/she is a drug addict and if offered drugs will consume them. The resident said he/she is stuck in the facility and still wants drugs. Resident #1 said the ADON offered him/her Xanax and as payment he/she wanted to have sex with him/her. The ADON also gave him/her Adderall and Tramadol (a drug used to treat pain). The ADON told the resident to meet him/her in an empty room to get the drugs. Resident #1 said when he/she would get to the room, the ADON would rub his/her genitalia to get the resident excited. The resident said he/she had intercourse with the ADON one time, and the ADON had performed oral sex once. The resident said he/she only had sex for the drugs. Resident #1 said he/she had talked to Resident #2 who told him/her the ADON had given Xanax to Resident #2 and rubbed his/her genitalia. During an interview on 03/23/26 at 12:07 A.M., Resident #2 said the ADON had given him/her two Xanax. Resident #2 said he/she is a drug addict, so if free drugs are offered, he/she will take them. The ADON had rubbed the resident's hair, shoulders and butt and moved his/her hand to the resident's genital area, but the resident walked away. The ADON attempted to kiss Resident #2 multiple times, but the resident said he/she would step away.<br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Resident #2 said the ADON had provided Resident #3 Xanax pills as well. During an interview on 03/23/26 at 4:00 P.M., Resident #3 said the ADON gave him/her two Xanax pills saying they would help with seizures. Resident #3 took one of the pills and he/she did not like how his/her body reacted. Resident #3 said he/she was in a sedated state when the ADON came back in his/her room and the ADON started to rub his/her genitalia. The resident said he/she pushed the ADON's hand away and he/she left. Resident #3 said he/she threw the other pill away. During an interview on 03/23/26 at 2:00 P.M., the ADON said Resident #1 stole medication from his/her purse while it was at the nurse's station. The ADON said he/she had not been informed of any allegations of sexual abuse, but the texts on the resident's phone were not from him/her. He/she said Resident #1 had been bothering HK A and the ADON had informed the ADM about the matter. The ADON said he/she was hanging around Resident #1 during his/her shifts to keep the resident away from HK A. The ADON did not say how Resident #1 got his/her phone number, or how the resident had an explicitly sexual text conversation with the ADON's personal cell number. The ADON denied the relationship. The ADON did not confirm his/her statements in the investigation about drugs in the facility. During an interview on 03/25/26 at 1:00 P.M., the AM said he/she observed Resident #1 outside in the back of the building, smoking what appeared to be marijuana. The AM said after informing the ADM, they entered the resident's room and found marijuana and a bottle of prescription medication of Xanax with the ADON's name on it. Resident #1 told the AM and ADM the ADON had given him/her the medication. During an interview on 03/23/26 at 1:30 P.M., Resident #1's Guardian (PA) said he/she wanted the resident to get therapy due to this mess. The PA said Resident #1 has a history of substance abuse and the facility should have protected him better. During an interview on 03/23/26 at 3:20 P.M., the DON said all the staff had been trained upon hire and there had been continual in-servicing on abuse and neglect. 2. The facility did not provide a policy on residents riding in staff personal vehicles or staff consuming marijuana with residents. Review of the facility's investigation dated 03/18/26, regarding the ADON offering pills for sexual favors, identified the following:- A statement from HK A, regarding any knowledge of Resident #1 owning or doing drugs, showed he/she was not aware of the relationship with the ADON, but had witnessed Resident #1 and the AD riding in a vehicle together and consuming marijuana;-No other investigation as to Resident #1 riding in the AD's vehicle while consuming marijuana or the AD driving while under the influence. During an interview on 03/23/26 at 11:00 A.M., the ADM said all staff were asked to write a statement for the situation regarding the ADON giving residents his/her Xanax. HK A wrote a statement saying the AD asked him/her to accompany him/her to the local store. When HK A got in the AD's personal vehicle, Resident #1 was in the front seat. HK A wrote the AD took them to a local dispensary first and went in and got marijuana to smoke in the car. The AD and Resident #1 smoked the marijuana in the car. The AD drove the car from the dispensary to the store while smoking the marijuana. The ADM said he had authorized the AD to take Resident #1 to the store but did not contact the Guardian for permission prior to and did not know any drugs were going to be purchased. The ADM said he would not have known about it, except HK A wrote it in a statement. During an interview on 03/23/26 at 11:40 A.M., Resident #1 said he/she had consumed marijuana with the AD and had made a deal to trade his/her prescribed Ambien (a medication used to promote sleep) for the costs. The resident said it was possible to purchase and consume marijuana at the facility. Resident #1 said he/she is a drug addict and if offered drugs will consume them. During an interview on 03/25/26 at 12:15 P.M., HK A said the AD told him/her to accompany him/her to the store to help with shopping. Resident #1 was in the AD's car. The AD told HK A the ADM had allowed the resident to go on the outing. The AD drove straight to the local dispensary from the facility. HK A said the AD and the resident went into the dispensary and came out with a purchase. The AD and the resident consumed the marijuana while in the vehicle and driving to the store. HK A said during the drive to the store, the AD told the resident that Resident #1 had to pay the AD back for the marijuana with an Ambien. Resident #1 agreed. HK A said he/she did not witness the exchange. HK A said he/she did not report the AD and Resident #1 sharing the marijuana, because<br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | he/she didn't know he/she was supposed to. HK A said he/she did not remember being told to report residents and staff doing drugs but confirmed his/her signature on the onboarding documents. During an interview on 03/23/26 at 1:30 P.M., Resident #1's PA said he/she wanted the resident to get therapy due to this mess. The PA said no one contacted him/her for permission for Resident #1 to leave the building with the AD in her personal car. He/she had not been aware of the resident going in a private vehicle with staff and consuming drugs. He/she would have expected the staff to have the resident's best interest at the forefront and to notify him/her prior to any outing. Allowing a person with a history of substance abuse and poor decision-making abilities access to drugs could have been detrimental to the resident. Allowing a staff member to drive a resident while under the influence of drugs could have been fatal for everyone. During an interview on 03/26/26 at 2:50 P.M., the facility physician said he/she does not recommend the use of marijuana with the residents due to the other medications the residents are taking. There would be a possibility of dangerous side effects and other problems, and it is not federally legal. The doctor said it is also a serious problem to enable a resident with a history of substance abuse to use again. It could be a huge setback in recovery. He/she said the staff member that had driven while under the influence was dangerous. At the time of the survey, the violation was determined to be at the immediate and serious jeopardy level J. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to address and lower the violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action be taken to address Class I violation(s). MO2809436 |