STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265509	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South County Health Care Center	1101 West Outer 21 Road 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.

(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 - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview and record review, the facility failed to provide wound care and medications as ordered for one resident (Resident #1) out of 10 sampled residents. The facility census was 82.The facility policy titled, Transcription of Orders and Following Orders, dated May 2024, showed:- The Licensed/Registered nurse will review electronic medication administration records (MARs) and treatment administration records (TARs) on a routine basis to monitor for medications that were not administered to the resident due to unavailability, refusal, omission and etc.;- If a medication is marked as not given, the reasoning for not being given should be explained in the progress notes and the Resident Care Coordinator (RCC), the Director of Nursing (DON), Assistant Director of Nursing (ADON), Registered Nurse (RN), and the Administrator must be notified. The physician and legal guardian (if applicable) must also be notified. The nurses progress notes must document the plan/solution because of the medication not being administered and any adverse reactions that the resident may have;- For the electronic MARs/TARs, the medication will be documented as not given by selecting the corresponding chart code for the reason why it was not given, and a progress note will be written;- The nurse or Certified Medication Technician (CMT) in charge of medication administration must review all their designated MARs/TARs prior to the end of their shift were administered/treatments scheduled to be given on their shift were administered according to the physician's order and that all necessary interventions were taken in the event of an omission. 1. Review of Resident #1's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 01/23/26, showed:- Diagnoses of sepsis (the body's extreme response to an infection), chronic kidney disease (impaired kidney function), hypotension, (low blood pressure), and irritant contact dermatitis (skin inflammation caused by contact with substances and/or environmental factors that injure the skin); - Cognition intact;- Able to make needs known;- Independent with tasks of eating and oral hygiene;- Substantial/maximal assistance of staff for toileting, shower/bath, upper and lower body dressing, personal hygiene and putting on/off footwear;- Urinary catheter (a sterile tube place in the bladder to drain urine) in place;- Occasionally incontinent of bowel; - One stage 3 pressure ulcer (full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle is not exposed. Slough (dead tissue) may be present but does not obscure the depth of tissue loss. May include undermining and tunneling) upon admission;- Open lesions other than ulcers, rash, cuts;- Surgical wound. Review of the resident's physician order sheet (POS), dated January through February 2026, showed:- An order, dated 01/21/26, for Ensure Plus (a nutritional supplement) two times a day, vanilla at breakfast and chocolate at dinner;- An order, dated 01/21/26, for Ensure Clear (a nutritional supplement) one time a day;- An order, dated 03/06/26, for ProSource Oral Liquid (a nutritional supplement) give 30 milliliters (ml) by mouth two times a day for wound healing;- An order, dated 01/21/26, for multivitamin-minerals one tablet by mouth one time a day for dietary deficiency;- An order, dated 01/21/26, for simethicone (medication used to treat excessive gas) 41.667 milligrams (mg) by mouth before meals and at bedtime for gas;- An order dated 01/21/26 for Loperamide HCl Oral Capsule 2 MG (Loperamide HCl) Give 1 capsule by mouth every 12 hours for diarrhea;- AN order dated 01/21/26 for Amoxicillin-Pot Clavulanate Oral Tablet 875-125 MG (an antibiotic) Give 1 tablet by mouth every 12 hours for lifelong suppression;- An order, dated (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 - Few	03/03/26, for midodrine (medication used to treat hypotension) 5 mg by mouth every 12 hours related to hypotension;- An order, dated 03/03/26, for pantoprazole sodium delayed release 40 mg by mouth one time a day for acid reflux;- An order, dated 01/21/26, to cleanse midline abdominal wound with wound cleaner, pat dry, apply betadine (used to treat minor wounds) and leave open to air two times a day for wound healing until 02/06/26;- An order, dated 01/22/26, to cleanse right hip wound with wound cleaner, pat dry, apply full strength Dakin solution (a wound treatment) to gauze and cover with absorbent dressing (ABD - dressing used to keep wounds dry) only if wound vac (vacuum-assisted closure used to conduct negative pressure wound therapy to promote healing) integrity is lost or off greater than 2 hours two times a day for wound healing;- An order, dated 01/22/26 for Negative Pressure Wound Therapy (NPWT) (a medical devices that use vacuum suction to treat acute or chronic wounds by removing fluid, reducing infectious material, and promoting healing) use with black foam - hip wound and white foam - sacral wound with continuous suction at 125MmHg one time a day every Tue, Fri for wound- An order, dated 01/22/26, for miconazole powder (a topical antifungal) apply to gluteal cleft (the deep vertical crease that separates the buttocks) to the perineum (the region between the anus and the genitals) topically two times a day related to irritant contact dermatitis due to fecal, urinary incontinence;- An order, dated 01/22/26, for Triad Hydrophilic Wound Dress External Paste (used for mild to moderate wound drainage) apply to gluteal cleft topically two times a day related to irritant contact dermatitis; - An order dated 01/22/26 to Cleanse Sacral wound with wound cleaner, pat dry, cover with pouch only if Vacuum integrity is lost or off greater than 2 hours two times a day for wound healing. Discontinued on 02/14/26. - An order, dated 02/14/26, cleanse right hip with wound cleaner, apply Dakin solution-soaked gauze to wound bed, cover with ABD and dry dressing twice a day when wound vac is off more than 2 hours every 12 hours as needed related to sepsis;- An order, dated 02/18/26 may remove wound vac for shower. Discontinued on 04/09/2026;- An order, dated 03/12/26, for wound care to clean right rip with wound cleanser, pat dry, apply calcium alginate (provides a moist environment for wound healing) and cover with a foam dressing and as needed (PRN) for dislodgement or drainage issues every day shift every Monday and Thursday for wound care until healed;- An order, dated 03/23/26, for zinc oxide external paste (helps protect the skin from moisture) apply to buttocks and rectal area topically two times a day for skin protectant until redness resolved, then PRN. Review of the resident's care plan, initiated on 04/07/26, showed:- At risk for adverse outcomes related to medication errors, including but not limited to incorrect medication administration, missed doses, wrong dose, wrong time, or documentation discrepancies, which may result in ineffective treatment, adverse drug reactions, or decline in condition. Review of the resident's TAR, dated January 2026, showed:- A treatment order for cleanse midline abdominal wound with 10 missed treatments out of 20 opportunities;- A treatment order for cleanse right hip wound with 10 missed treatments out of 20 opportunities;- A treatment order for cleanse sacral wound with 10 missed treatments out of 20 opportunities;- A treatment order for gluteal cleft wound with 10 missed treatments out of 20 opportunities. Review of the resident's MAR, dated January 2026, showed:- An order for simethicone tablets with six out of 40 missed opportunities. Review of the resident's TAR, dated February 2026, showed:- An order for wound vac on the sacral (triangular bone located above the coccyx) wound and hop wound change missed three times out of eight opportunities; - A treatment order for cleanse midline abdominal wound with three missed treatments out of 12 opportunities;- A treatment order to cleanse right hip wound with four missed treatments out of 28 opportunities;- A treatment order to cleanse sacral wound with four missed treatments out of 28 opportunities;- A treatment order for gluteal cleft wound with 16 missed treatments out of 56 opportunities;- A treatment order for wound dressing to gluteal hip wound with three missed treatments out of 12 opportunities. Review of the resident's TAR, dated March 2026, showed:- An order for wound vac on sacral wound and hip wound change missed two times out of two opportunities; - An order for dressing to sacral wound with two missed treatments out of 20 opportunities;- An order for gluteal cleft wound treatment with 13 missed treatments out of 20 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	opportunities. Review of the resident's TAR, dated March 2026, showed:- An order for dressing to sacral wound with one missed treatment out of eight opportunities;- An order for treatment to buttocks and rectal area with one missed treatment out of 17 opportunities. Review of the resident's MAR, dated March 2026, showed:- An order for Ensure Plus chocolate flavor at dinner with five out of 18 missed opportunities;- An order for Ensure Clear one time a day with two out of nine missed opportunities; - An order for ProSource Nutritional supplement two times a day with five out of 18 missed opportunities;- An order for pantoprazole sodium 40 mg one time a day with two out of nine missed opportunities;- An order for multivitamin-minerals tablet one time a day with two of nine missed opportunities;- An order for amoxicillin 875-125 mg tablet with three out of 18 missed opportunities; - An order for loperamide (medication used to treat diarrhea) capsule every 12 hours with three out of 18 missed opportunities; - An order for midodrine tablet every 12 hours with three out of 18 missed opportunities; - An order for simethicone tablets every 12 hours with nine out of 36 missed opportunities. Review of the residents' Progress Notes showed no documentation of missed medication and/or treatments. During an interview on 04/15/26 at 11:45 A.M., the Corporate Consultant said she would expect all nursing and certified medication technicians to document medications or treatments given and if not done, document the reason why and contact the physician if needed. MO2969985

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on closed record review and interview, the facility failed to provide bathing/showers for one resident (Resident #1) of 10 sampled residents. The facility census was 82.The facility policy titled Resident Showers and dated June 2024, directed staff to: - Assist residents with bathing to maintain proper hygiene, stimulate circulation and help prevent skin issues as per current standards of practice;- Provide residents with showers as requested or as per facility schedule protocols and based upon resident safety; The facility did not provide a resident shower/bathing schedule. 1. Review of Resident #1's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated January 23, 2026, showed:- An admission date of 01/21/26;- Diagnoses of sepsis (a life-threatening medical emergency caused by an overwhelming immune response to infection, leading to tissue damage, organ failure, and death), chronic kidney disease (a serious, long-term condition where kidneys are damaged and cannot effectively filter blood, often leading to waste buildup), hypotension, (abnormally low blood pressure), and irritant contact dermatitis a common, non-allergic skin reaction caused by direct damage from substances like soaps, cleaners, or chemicals, resulting in a painful or itchy, red, cracked rash);- Cognitively intact;- Able to make needs known;- Substantial/maximal assistance of staff for toileting, shower/bath, upper and lower body dressing, personal hygiene and putting on/off footwear;- Foley catheter (a tube place in the bladder to drain urine) in place;- Occasionally incontinent of bowel; - One stage 3 pressure ulcer (Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling) upon admission;- Open lesions other than ulcers, rash, cuts;- Surgical wound. Review of Resident #1's care plan, dated 01/22/26, showed no interventions for assistance of staff for personal hygiene and/or activities of daily living. Review of facility shower records showed Resident #1 received a shower on 01/29/26, 03/03/26 and 04/02/26. There were no recorded bed baths. During an interview on 04/14/26 at 11:00 P.M., the Corporate Consultant (CC) said there was no shower schedule. Staff had been doing showers by randomly selecting residents and did not document. The CC said she would expect staff to have a shower schedule and record all showers and/or bed baths per facility policy. Cmp 2969985