

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: 265509	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/16/2026
NAME OF PROVIDER OR SUPPLIER South County Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to provide residents with a clean, comfortable and homelike environment by failing to maintain resident-use areas, bathing areas and common areas in a sanitary and orderly condition. This deficient practice had the potential to affect all residents residing in the facility. The facility census was 80. The facility did not provide a policy for a safe, clean, and comfortable homelike environment. Review of the Resident Council minutes from the 02/11/26 meeting showed a concern with housekeeping and not getting the rooms cleaned. There was no follow-up included. Observation on 06/16/26 at 9:00 A.M., during the initial tour of the facility showed a strong urine odor upon entering. Observations on 06/16/26 at 9:12 A.M. of the 300-hall showed: A dried tissue with black substance that had been streaked across the floor and left in front of the men's and women's bathrooms on the 300 hall; The female bathroom had an out of order sign posted on the door; The floor throughout the 300 hall was heavily streaked with a brown substance; The metal drain covers in the hallway had a black substance around edges; A 5-gallon bucket full of brown stained blankets sat in front of the dirty utility room; A gray, plastic square trash can with a brown stained blanket sat in front of the dirty utility room; A tied clear trash bag sat next to the 5-gallon bucket; A clear trash bag with a brown colored garment sat near the gray trash can; A white plastic laundry basket with resident blanket and clothing sat in the hall. Observations on 06/16/26 at 9:16 A.M. of room [ROOM NUMBER] showed: The floor in the bathroom had areas of brown stains on the floor; A black substance to floor around base of toilet; The bathroom door had scuff marks; The wall above the tile baseboard had an exposed area of concrete; The resident room trash can near the sink was full and overflowing; A white mesh bag with clothing, a pair of pants and a flat sheet on the floor in front of the sink; The sink was cluttered with personal items; There were dried brown spots and brown wheelchair tracks on the floor throughout the room; The floor was covered with black dirt like debris. Observation on 06/16/26 at 9:25 A.M. of the Nurse's Station on the Countryside Hall showed: A white, wheeled cart with yellowed handles had dried brown spots to handles and sides; An ice chest, filled with ice sat on top of the cart with the lid opened and leaning against the wall; A large metal ice scoop sat on the right side up on a piece of fabric next to the ice chest. Brownish water had pooled in the deepest part of the scoop. Observations on 06/16/26, from 9:26 A.M. to 9:40 A.M. of the Countryside 100 Hall showed: The male bathroom had brown footprint outlines throughout on the floor. The toilet in the bathroom had a dark brown substance on the floor at base; A four-tile square in the middle of the 100 Hallway covered with four tiles. One tile was missing a corner, leaving a hole to the subfloor; A one-gallon jug of an industrial strength cleaner sat on the floor. The jug did not have anti-tamper type lid; Dried droplets of a black substance on the floor at the end of hall; Several dead bugs scattered on the floor at the end of the hall; The shower room had a thick black substance on the tile surface ledges and a reddish black substance on the tile walls, corners, and tile floors; Two wheelchair cushions and three wheelchair footrests on the floor and up against the radiator heater; The base of the toilet was covered in a brownish black substance; Brownish black spots to the outside rim of the toilet; The toilet paper roll sat on the floor with toilet (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	paper holder;The baseboards had splatters of a black substance; A used towel lying on a bariatric shower seat;The bariatric shower seat had 2 pieces of duct like tape on the left leg;A bed in hallway with fitted sheet covered in small holes and brown stains;room [ROOM NUMBER] dried brown dirt like substance in front of chair on the floor and footprints throughout the room. A bath blanket covered with a dark brown substance lay on the floor in front of the sink; The closet at the end of the 100 hallway with door off placed and in the closet leaning against an open cardboard box with blue linen partially out and a plastic bag on the floor containing pillows; The sheet on the bed in room [ROOM NUMBER] bed had dark brown ring and two smaller brown spots. During an interview on 06/16/26 at 1:00 P.M., the DON and the Administrator said they expected the environment to be clean and sanitary.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review and interview the facility failed to maintain hazardous cleaning chemicals in a secure manner to prevent resident access when an unattended one-gallon container of cleaning solution was observed on the floor in a resident accessible hallway. The product was identified by the manufacturer as causing serious eye irritation and potentially harmful if swallowed. The facility's assessment identified that 40 of the 80 residents had behavioral health needs, making resident access to hazardous chemical a foreseeable accident hazard. The facility census was 80. Observation on 06/16/26 at 9:26 A.M., showed an unattended one-gallon container of a purple cleaning solution sitting on the floor in the Countryside 100 and resident-accessible hallway. Review of the manufacturer's Safety Data Sheet identified the product as causing serious eye irritation and noted it may be harmful if swallowed. Review of the facility assessment identified 35 residents with behavioral symptoms and cognitive impairment and 40 residents with behavioral health needs. Failure to secure hazardous cleaning chemicals created the potential for residents to ingest, spill or otherwise be exposed to the cleaning solution, placing residents at risk for injury. During an interview at 06/16/26 at 1:00 P.M., the administrator said the jug of purple liquid was just the cleaner housekeeping puts into spray bottles.		