

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/07/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265735	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/25/2025
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ESTATES OF HIDDEN LAKE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 11728 HIDDEN LAKE DRIVE SAINT LOUIS, MO 63138
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 658 SS=D	<p>Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)</p> <p>§483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to meet professional service standards when staff did not investigate the case of an injury after the discovery for one resident (Resident #1) after the resident had a right foot fracture. Facility staff did not notify family of the resident change in condition. In addition, the facility did not completely transcribe or clarify orders from hospital emergency room. The sample was 4, census was 53.</p> <p>Review of facility's Accident and Incident Investigation Guidelines policy, undated, showed:</p> <ul style="list-style-type: none"> -An accident/incident investigation is not designed to find fault or blame, it is an analysis to determine causative factors that can be controlled or eliminated to prevent future occurrences, potential injuries, or abuse; -Investigation Process: As soon as an incident is known a licensed nurse, or other department director(s) will investigate causative factors and, as soon as possible, remove any person or item which would cause further harm or injury; -A nurse should begin the initial investigation of the incident, as soon as possible, by: <ul style="list-style-type: none"> -Determining if an injury occurred, performing appropriate assessments, and providing emergency care and seeking medical intervention when necessary; -Determining the extent of the injury and the 	F 658		
---------------	---	-------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER/REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE **3/14/25**

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265735	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/25/2025
NAME OF PROVIDER OR SUPPLIER ESTATES OF HIDDEN LAKE, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 11728 HIDDEN LAKE DRIVE SAINT LOUIS, MO 63138		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 658	Continued From page 1 medical intervention necessary to prevent further physical injury or mental pain; -Securing the names of all individuals present at the time of the occurrence - or description of individuals un-named; -Requesting a written statement of what occurred from the nurse and Certified Nurse Assistant (CNA) assigned to the resident's care; -Interviewing individuals present at the time of the incident or similar incidents: other residents, other employees, visitors, others in the building at the time of the occurrence; -Determining the location, date, and time of the occurrence; -Determining how the incident could have occurred; -Obtain written statements from other individual(s) present before they leave the building, look for differences between what witnesses say occurred; -Inspection of the environment for causative factors; -Reviewing the actual use of assistive devices per care plan and physician order; -Reviewing staff adherence to care plan in transferring residents from one location to another or other mobility issues; -Reviewing staff adherence to CNA assignment for Activities of Daily Living (ADL) assistance; -Determine caregiver knowledge of how to identify an accident/incident; -If an injury occurred, the resident must be assessed promptly; -Appropriate emergency care provided; -Notification made to physician, administrator, Director of Nursing (DON), police, ambulance, family/sponsor, other caregivers; -Ensure resident is properly protected during investigation;	F 658			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265735	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/25/2025
NAME OF PROVIDER OR SUPPLIER ESTATES OF HIDDEN LAKE, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 11728 HIDDEN LAKE DRIVE SAINT LOUIS, MO 63138		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 658	<p>Continued From page 2</p> <ul style="list-style-type: none"> -Place information on the 24-hour report; -Scheduling appropriate timely assessments; -Follow up on effectiveness of interventions. <p>Review of facility's Notification of Change Guideline, dated 10/01/2021, showed:</p> <ul style="list-style-type: none"> -Purpose: It is the practice of this facility that changes in a resident condition or treatment are immediately shared with the resident and/or the resident representative, according to their authority, and are reported to and consulted with the attending physician. The resident and/or the resident representative will be educated about treatment options and supported to make an informed decision; -Objective of the notification of change guideline is to ensure facility staff make appropriate notification to the physician or delegated Non-Physician Practitioner and immediate notification to the resident and/or the resident representative when there is a change in condition; -Requirements for notification of resident, the resident representative, and their physician include: <ul style="list-style-type: none"> -A significant change in the resident's physical, mental, or psychosocial status; -An accident involving the resident, which results in injury and has the potential for requiring physician intervention; -Procedure: The facility shall promptly notify the resident and/or the resident representative and consult with the physician with changes in the resident's condition or status by: <ul style="list-style-type: none"> -Obtain orders for appropriate treatment and monitoring and promote the resident's right to make choices about treatment and care preferences; -Document the notification and record any new 	F 658			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265735	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/25/2025
NAME OF PROVIDER OR SUPPLIER ESTATES OF HIDDEN LAKE, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 11728 HIDDEN LAKE DRIVE SAINT LOUIS, MO 63138		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 658	<p>Continued From page 3</p> <p>orders in the resident's medical record;</p> <ul style="list-style-type: none"> -Educate the resident and/or representative about the proposed plan to treat, manage or monitor the resident's change in condition; -Educate the resident and/or resident representative about the risks and benefits of the proposed treatment change and provide an opportunity for the resident to make an informed choice of treatment; -Update the resident's care plan, transcribe, and implement the provider's orders; -Communicate the changes to the care team and pharmacy. <p>Review of Resident #1's medical record, showed:</p> <ul style="list-style-type: none"> -Diagnoses included stroke, dementia, unspecified psychosis, and high blood pressure; -Brief Interview for Mental Status (BIMS), dated 12/30/24, showed severe cognitive impairment; -A diagnostic x-ray dated 2/1/25 at 2:37 P.M., showed right foot two view results. The bones appear diffusely demineralized (widespread loss of minerals from bones resulting in fragile bones). Acute non-displace 5th metatarsal (foot bone) base fracture. <p>Review of the resident's hospital after visit summary note, dated 2/1/25, showed:</p> <ul style="list-style-type: none"> -Diagnoses: acute bilateral (both side) ankle pain, closed nondisplaced fracture of fifth metatarsal bone of the right foot; -Schedule an appointment as soon as possible in one week with the follow-up physician; -Schedule an appointment for follow-up in three weeks with an orthopedic specialty; -Medium Boot applied; -Home Care: <ul style="list-style-type: none"> -You may be given a splint, cast, shoe, or boot to keep the injured area from moving. Unless you 	F 658			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265735	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/25/2025
NAME OF PROVIDER OR SUPPLIER ESTATES OF HIDDEN LAKE, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 11728 HIDDEN LAKE DRIVE SAINT LOUIS, MO 63138		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 658	<p>Continued From page 4</p> <p>were told otherwise, use crutches or a walker. Don't put weight on the injured foot until your healthcare provider says you can do so;</p> <ul style="list-style-type: none"> -Keep your leg elevated to reduce pain and swelling. When sleeping, put a pillow under the injured leg. When sitting, support the injured leg so it is above your heart; -Put an ice pack on the injured area. Do this for 20 minutes every one to two hours the first day for pain relief. Continue using the ice pack three to four times a day for the next two days. Then use the ice pack as needed to ease pain and swelling; -Keep the splint, cast boot, or shoe dry; -You may use acetaminophen (Tylenol) or ibuprofen to control pain unless another pain medicine was prescribed. <p>Review of the resident's physician order sheet, showed:</p> <ul style="list-style-type: none"> -An order dated 2/1/24, cast care boot to right foot on while up for pain, watch for skin breakdown; -An order dated 2/11/24, tape great right toe to second toe for alternative healing measures two times a day; -No order for ice pack to injured foot; -No order for elevation with pillow to injured foot. <p>Review of the resident's Treatment Administration Record (TAR), dated February 2025, showed:</p> <ul style="list-style-type: none"> -Treatment scheduled to tape great right toe to second toe for alternative healing measures two times a day, dated 2/11/25, and marked as completed two times a day from start date; -Scheduled cast care boot to right foot while up for pain, watch for skin breakdown scheduled seven times a day from start date 2/3/25; 	F 658			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265735	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/25/2025
NAME OF PROVIDER OR SUPPLIER ESTATES OF HIDDEN LAKE, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 11728 HIDDEN LAKE DRIVE SAINT LOUIS, MO 63138		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 658	<p>Continued From page 5</p> <p>-No schedule for ice pack or elevation to injured foot.</p> <p>Review of the resident's care plan, initiated 2/4/25, showed:</p> <p>-Focus: Resident has a bone fracture to his/her right foot. He/She is at risk for slow, delayed healing to the foot related to removal of boot cast. Removal of tape from toes;</p> <p>-Goal: The resident will not develop complications or permanent loss of mobility related to fracture through review date;</p> <p>-Interventions included:</p> <p>-Apply cast boot to right lower extremity and remind resident to leave the cast boot on especially if ambulation;</p> <p>-Encouragement and/or reminders to leave tape in place to the toes;</p> <p>-Give pain, anti-inflammatory medications as ordered. Monitor/document side effects and effectiveness;</p> <p>-Monitor/document/report as needed for edema (swelling), bruising/discoloration of skin, skin temperature changes, loss of sensation distal to fracture, presence/absence of pulses distal to fracture. If cast is present, skin breakdown or trauma at cast edges;</p> <p>-Support injured area with pillows and immobilize part as appropriate.</p> <p>Review of the resident's progress notes, showed:</p> <p>-On 1/31/25 at 6:37 P.M., resident complains of pain to top of right foot. Call placed to physician's exchange. Awaiting a call back for possible new orders;</p> <p>-On 1/31/25 at 10:32 P.M., received return call from Medical Doctor (MD) new order for two view STAT (right now/immediate) x-ray of right foot and ankle;</p>	F 658			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265735	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/25/2025
NAME OF PROVIDER OR SUPPLIER ESTATES OF HIDDEN LAKE, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 11728 HIDDEN LAKE DRIVE SAINT LOUIS, MO 63138		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 658	Continued From page 6 -On 2/1/25 at 6:12 A.M., contacted X-ray for estimated time of arrival. Stated exam scheduled for today. Will put a call out to technician to contact facility with a time. Resident lying in bed resting at this time. Shows no signs or symptoms of pain or discomfort. No redness or swelling observed; -On 2/1/25 at 1:15 P.M., x-ray technician here at this time, all x-rays of right foot and ankle completed. Resident tolerate x-ray without difficulty; -On 2/1/25 at 2:00 P.M., grandchild here at this time to take resident out on leave of absent (LOA) requesting wheelchair related to resident complaint of right foot pain. Explained that we are waiting on x-ray results. Resident currently LOA; -On 2/1/25 at 3:09 P.M., received call from the resident's family, related to resident having to have x-rays taken of right foot. Informed that this writer would notify him/her once x-ray results were obtained. Family also states that he/she will call on 2/3/25 related to not being notified that resident needed x-rays to be obtained; -On 2/1/25 at 5:33 P.M., resident remains LOA currently; -On 2/1/25 at 7:35 P.M., call received from family, informed this writer that grandchild has taken resident to the Emergency Room (ER) for evaluation and that resident does have fracture to right foot and they are not sure if resident is going to be admitted. Will call facility with further information and update if resident is to be admitted. Family would like to be notified if x-ray results are sent to facility; -Administrator's note on 2/1/25 at 8:08 P.M., spoke with family about the resident's ER visit and he/she is updating other family, of our conversation. He/She informed the administrator that the resident's grandchild came to get the	F 658			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265735	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/25/2025
NAME OF PROVIDER OR SUPPLIER ESTATES OF HIDDEN LAKE, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 11728 HIDDEN LAKE DRIVE SAINT LOUIS, MO 63138		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 658	<p>Continued From page 7</p> <p>resident for their routine LOA visit but noted the resident in the wheelchair and the staff informed him/her of the pain and x-ray. The grandchild ended up taking the resident to the ER because he/she was concerned about the resident having difficulty walking. He/She verbally reported that the resident has a fracture of a toe which one he/she is not certain. The administrator informed him/her staff noticed he/she had no signs of injury like bruising or swelling. Records and staff communication revealed no fall, and nothing was in his/her room that could be considered heavy and would have fallen on his/her foot;</p> <p>-On 2/1/25 at 10:08 P.M., resident transported to facility from Hospital in a car accompanied by family. Wheelchair used to transport resident to room and place in bed. Resident is alert to self, skin warm and dry, respiration even and unlabored, right foot fracture, cast boot for comfort;</p> <p>-On 2/11/25 at 12:30 P.M., call placed to physician to request orders related to resident continuously removing boot from right foot. New order to tape great right toe (large toe) to second toe right toe for alternative healing measures two times a day. Updated in electronic medical record;</p> <p>-No note the care instructions from the ER visit for ice and elevation was reviewed with the physician;</p> <p>-No clarification regarding the residents 5th toe being broken and why the order specified taping the big toe to the second toe and not the 4th toes to the 5th toe.</p> <p>Observation on 2/24/25 at 8:55 A.M., showed the resident walked around in his/her room pleasantly confused and smiled, unable to say his/her name or answer questions. He/She wore a nightgown</p>	F 658			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265735	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/25/2025
NAME OF PROVIDER OR SUPPLIER ESTATES OF HIDDEN LAKE, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 11728 HIDDEN LAKE DRIVE SAINT LOUIS, MO 63138		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 658	<p>Continued From page 8</p> <p>with no socks or shoes on, no boot on and no tape on the resident's toes. A black walking boot was present in the room next to nightstand under the window. At 9:50 A.M., the resident sat in the dining room eating breakfast, dressed in clothes with sock and boot on the right foot and a sock and shoe on the left foot.</p> <p>Observation on 2/25/25 at 10:03 A.M., showed the resident sat in the common area next to the dining room with a boot on his/her right foot. Licensed Practical Nurse (LPN) A walked the resident down to his/her room and removed the boot. Observation showed all toes taped together and the LPN said the orders are confusing because he/she thought the injury was to the little toe not the big toe, which is what the order has big toe tape to second toe, so he/she tapped them all together.</p> <p>During an interview on 2/24/25 at 10:02 A.M., Registered Nurse (RN) D said he/she does not know what happened to the resident's foot but he/she has a fracture to his/her right fifth toe.</p> <p>During an interview on 2/24/25 at 10:05 A.M., LPN E said the staff must tape resident's toe for support because he/she will not leave his/her boot on.</p> <p>During an interview on 2/24/25 at 12:50 P.M., the Administrator said if a resident is having pain or a change in condition, the physician and family should be notified immediately and orders from physician obtained if necessary. They cannot order STAT x-rays or labs because they do not have access to these services immediately. If the physician requires STAT to an order the resident should be sent to the ER for evaluation. The</p>	F 658			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265735	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/25/2025
NAME OF PROVIDER OR SUPPLIER ESTATES OF HIDDEN LAKE, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 11728 HIDDEN LAKE DRIVE SAINT LOUIS, MO 63138		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 658	<p>Continued From page 9</p> <p>facility does not have a policy and procedure for STAT orders and they need to call the medical director for clarification and understanding of time frame for STAT orders.</p> <p>During an interview on 2/24/25 at 6:40 A.M., LPN B said he/she worked 1/31/25 at 7:00 P.M. to 2/1/25 at 7:00 A.M. and when he/she arrived to work the resident was in bed. LPN A reported to him/her that the resident had been complaining of right foot pain and to call the physician for an x-ray order. He/She called the physician for a STAT x-ray order of the resident's right foot. He/She checked on the resident several times through the night and the resident slept all night in bed and when he/she palpitated the resident's foot, the resident did not grimace or move his/her foot. There were no signs or symptoms of swelling or bruising. The Administrator calls in every morning around 4:00 A.M. to check on the facility, staff, and residents. When she called, LPN B informed her about the resident's foot and the STAT x-ray order. That is when he/she found out the facility does not have a STAT order for labs and x-rays and if a STAT order is needed then the resident needs to be sent to the ER. The Administrator said the day shift will follow up with x-ray for the resident. He/She never called the family because he/she assumed LPN A had done that. The resident remained in bed all night on his/her shift. When the next shift came in, he/she told them to check on the status of the x-ray.</p> <p>During an interview on 2/24/25 at 7:00 A.M., RN C said he/she did not get a report on the resident from the off going shift and was not aware the resident had an issue with his/her foot until staff got the resident up for breakfast and told him/her they had to use a wheelchair because he/she</p>	F 658			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265735	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/25/2025
NAME OF PROVIDER OR SUPPLIER ESTATES OF HIDDEN LAKE, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 11728 HIDDEN LAKE DRIVE SAINT LOUIS, MO 63138		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 658	<p>Continued From page 10</p> <p>could not walk to the dining room. He/She looked in the computer and saw an x-ray had been ordered. He/She followed up on x-ray to see when they would arrive. The x-ray happened after lunch. The grandchild came in after the x-ray to pick the resident up for a LOA, this is routine for this grandchild, and asked why the resident was in a wheelchair and he/she said he/she is complaining of foot pain and an x-ray has just been done and we are waiting on the results. He/She did not know he/she was taking the resident to the ER until the family called and said the resident has a toe fracture. He/She never heard what caused the fracture, but assumed the resident walks around all the time, and hit his/her toe on something. A STAT order means as soon as possible, about two to three hours. How long it took for the resident to receive the x-ray was not a STAT order. He/She did not know the family had not been notified but they should have been notified immediately that the resident was having foot pain.</p> <p>During an interview on 2/25/25 at 7:26 A.M., LPN A said it was at the end of his/her shift and he/she had already reported off to the nurse coming on when he/she was told by staff the resident was limping and complaining of pain. He/She went to the resident's room and assessed the foot, and resident had no signs or symptoms of pain upon palpitation, swelling, redness, or bruising. Only when he/she got up to walk did he/she limp and grimace in pain. He/She told the oncoming nurse that he/she had not done anything because he/she was just told by the aide that the resident was having issues.</p> <p>During an interview on 2/25/25 at 11:25 A.M., the Administrator said the family should be notified as</p>	F 658			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265735	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/25/2025
NAME OF PROVIDER OR SUPPLIER ESTATES OF HIDDEN LAKE, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 11728 HIDDEN LAKE DRIVE SAINT LOUIS, MO 63138		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 658	Continued From page 11 soon as possible if a resident has a change in condition including limping or pain in the foot. She would expect an investigation following an injury of unknown origin to be completed when a resident has a fractured toe so staff can determine what may have caused the fracture to make sure an avoidable issue does not exist. The outcome of the investigation should be followed up with the family. She expected all staff to follow physician orders, make sure they are correct before they give medication or complete treatment and if orders are unclear, she expects them to call for clarification. Nursing staff should never document an order as completed if it was not completed as written. All dressings should be initialed, dated, and timed with completion of treatment. STAT orders mean as soon as possible. She has discussed with facility staff the need for clarification from physicians as to orders that can be completed STAT at the facility and orders that if a STAT reading is needed the resident will need to be sent to the ER. STAT orders need parameters clarification and education completed with physician and staff. The order for STAT x-ray should have been clarified with the physician to see if the resident needed to be sent to ER, or a time frame for completion. Family should have been notified as soon as the resident started limping and complaining of pain.	F 658			
F 686 SS=D	MO00248941 Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a	F 686			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265735	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/25/2025
NAME OF PROVIDER OR SUPPLIER ESTATES OF HIDDEN LAKE, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 11728 HIDDEN LAKE DRIVE SAINT LOUIS, MO 63138		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 686	<p>Continued From page 12</p> <p>resident, the facility must ensure that-</p> <p>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and</p> <p>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed ensure a resident with pressure ulcers (injury to the skin and/or underlying tissue, as a result of pressure or friction) receives necessary treatment and service to promote healing when staff did not provide wound care to one resident (Resident #4) according to physician orders and facility policy and procedures. Four residents were sampled. The census was 53.</p> <p>Review of facility policy and procedure for Dressing Non-Sterile Aseptic Technique, undated, showed:</p> <ul style="list-style-type: none"> -The purpose of this procedure is to provide guidelines for the application of non-sterile dressings: -Preparation: <ul style="list-style-type: none"> -Verify that there is a physician's order for this procedure; -Review the resident's care plan, current orders, and diagnoses to determine if there are special resident needs; -Check the treatment record; -Procedure: <ul style="list-style-type: none"> -Bring supplies into resident's room. Cut strips 	F 686			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265735	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/25/2025
NAME OF PROVIDER OR SUPPLIER ESTATES OF HIDDEN LAKE, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 11728 HIDDEN LAKE DRIVE SAINT LOUIS, MO 63138		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 686	<p>Continued From page 13</p> <p>of tape adequate for securing dressing and add date and initials or if adhesive dressing used, label dressing at this time;</p> <p>-Documentation: The following information should be recorded in the resident's medical record or Treatment Administration Record (TAR):</p> <ul style="list-style-type: none"> -The date and shift the dressing was changed; -The initials of the individual changing the dressing; -The type of dressing used, and wound care given. <p>Review of Resident #4's medical record, showed:</p> <ul style="list-style-type: none"> -Hemiplegia (paralysis on one side of the body) and hemiparesis (weakness or paralysis on one side of the body) following cerebral infarction (stroke) affecting right dominant side of body, acute upper respiratory infections, aphasia (difficulty speaking), high blood pressure, epilepsy (seizure disorder), dysphagia (swallowing difficulty), diabetes, and unhealed pressure ulcers; -Brief Interview for Mental Status (BIMS) assessment dated 11/29/24, showed severe cognitive impairment. <p>Review of the resident's physician orders, showed:</p> <ul style="list-style-type: none"> -An order, dated 12/11/23, for Prevalon boots (cushion boot designed to help reduce the risk of heel pressure injury), on at all times while in bed for offloading every shift for pressure injury; -An order dated 1/23/24, for Skintegrity 2 (foam dressing with border tape) apply to left heel topically every day shift for skin protection, apply border foam dressing and heel protectors; -An order dated 2/24/25, for Cavilon (skin prep, protective barrier wipe). Apply to affected area (area not specified) topically every eight hours as 	F 686			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265735	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/25/2025
NAME OF PROVIDER OR SUPPLIER ESTATES OF HIDDEN LAKE, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 11728 HIDDEN LAKE DRIVE SAINT LOUIS, MO 63138		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 686	<p>Continued From page 14 needed for skin protection; -No orders to cleanse left heel wound with cleanser.</p> <p>Review of Wound Company progress visit report, dated 1/8/25 at 5:45 A.M., completed by the wound company Nurse Practitioner (NP), showed: -Patient presents with suspected deep tissue injury (DTI, a type of pressure injury that occurs when prolonged pressure or shear forces damage the underlying soft tissues, such as muscles, tendons, and bones) to left heel; -The wound is a 2 by 3 (no unit of measurement) area of deep purple. The skin is currently intact; -Wound Care Orders: -Cleanse wound with cleanser, protect peri-wound (skin surrounding wound) with skin prep, cover wound with bordered foam dressing, change daily and as needed for soiling or saturation; -Pressure Relief/Offloading: -Resident on low air loss mattress, offload heels with Prevalon boots. Patient should always have on heel protectors when in bed.</p> <p>Review of the resident's wound weekly observation tool, dated 1/8/25 at 10:37 A.M., showed wound to left heel, DTI, unstageable, measured 2 centimeters (cm) long by 3 cm wide. Continue skin prep with boarder foam dressing.</p> <p>Review of the resident's progress note, dated 1/8/25 at 10:31 A.M., written by Registered Nurse (RN) C, showed wound care completed per wound company NP. The residents physician/medical director and resident family notified of resident being seen and evaluated by wound NP with orders to continue with skin prep</p>	F 686			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265735	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/25/2025
NAME OF PROVIDER OR SUPPLIER ESTATES OF HIDDEN LAKE, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 11728 HIDDEN LAKE DRIVE SAINT LOUIS, MO 63138		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 686	<p>Continued From page 15</p> <p>and border foam dressing to left heel. DTI measures 2 by 3 (no unit of measurement), resident to have protective boots on at all times.</p> <p>Observation and interview on 2/24/25 at 10:29 A.M., showed the resident lay in bed awake with both heels flat on the bed, no pillow support to off load heels and no heel protector boots on the resident's heels. The resident said he/she is doing fine and denied having a dressing to his/her heel. At 10:32 A.M. Certified Nursing Assistant (CNA) H entered the resident's room to check on the resident. CNA H asked the resident if he/she is ready to get up and the resident replied yes. Observation showed no dressing to left heel, and a quarter size black and deep purple spot on left heel. CNA H said the resident does not have a dressing to the heel and is supposed to wear heel protecting boots all the time to help protect resident heels. He/She does not know why the boots were not on the resident's feet.</p> <p>During an interview on 2/24/25 at 1:55 P.M., Licensed Practical Nurse (LPN) G said the resident's order for the left heel is to apply skin prep and he/she completed the task earlier in the day. When asked if it receives any kind of dressing, he/she replied the resident has heel boots to help protect the heel and skin prep, no dressing.</p> <p>During an interview on 2/24/25 at 2:20 P.M., LPN G said he/she checked the resident's orders prior to completing the task. After checking the order, LPN G said he/she did not know the order had changed to apply a dressing. He/She has only been using skin prep to the heel and has never applied a dressing. He/She said all orders should be verified prior to completing the treatment.</p>	F 686			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265735	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/25/2025
NAME OF PROVIDER OR SUPPLIER ESTATES OF HIDDEN LAKE, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 11728 HIDDEN LAKE DRIVE SAINT LOUIS, MO 63138		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 686	<p>Continued From page 16</p> <p>He/She looked up the order and said the order changed on 1/23/25. He/She was not aware of the change and has not completed the order correctly since 1/23/25.</p> <p>Observation on 2/25/25 at 8:05 A.M., showed the resident awake in bed with heel protectors on. When asked if there is a dressing to the wound on the left heel the resident said yes.</p> <p>Observation on 2/25/25 at 12:26 P.M., showed RN C removed the resident's left heel boot and pulled back the intact foam dressing with border from the heel. The dressing was dated 2/25/25 with nursing initials present. RN C measured the wound at 2 cm long by 1.5 cm wide. He/She reapplied the dressing. No signs or symptoms of drainage noted on dressing.</p> <p>During an interview on 2/25/25 at 12:45 P.M., the Administrator said all nursing staff should review all orders prior to administering medications and treatments. She would expect nursing staff to check the order prior to completing the treatment or administering the medications. She also expected all nurses to check the orders and if they need clarification to call the physician for clarification. Nursing staff should check progress notes daily to review continuity of care. Progress notes are a form of communication between the resident's medical providers and nursing staff. On 3/3/25 at 10:33 A.M., the Administrator said all wounds are measured and recorded in centimeters.</p> <p>MO00249248</p>	F 686			

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18442	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/25/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ESTATES OF HIDDEN LAKE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 11728 HIDDEN LAKE DRIVE SAINT LOUIS, MO 63138
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4075	<p>19 CSR 30-85.042(66) Nursing Care per Res Condition</p> <p>Each resident shall receive personal attention and nursing care in accordance with his/her condition and consistent with current acceptable nursing practice. I/II</p> <p>This regulation is not met as evidenced by: Class II</p> <p>See deficiency cited at F658.</p>	A4075		
A4083	<p>19 CSR 30-85.042(74) Pressure Sore Prevention/Treatment</p> <p>Facilities shall keep residents free from avoidable pressure sores, taking measures toward prevention. If sores exist, staff shall give adequate treatment. I/II</p> <p>This regulation is not met as evidenced by: Class II</p> <p>See deficiency cited at F686.</p>	A4083		

Missouri Department of Health and Senior Services
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Signature]
Administrator

TITLE

[Signature]
3/14/25


(X8) DATE

PLAN OF CORRECTION

Provider/Supplier Name:	ESTATES OF HIDDEN LAKE	
Street Address, City, Zip:	11728 HIDDEN LAKE DR SAINT LOUIS MO 63138	
Date of Survey:	02/25/25	
PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		265735 18442
ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	This plan of correction is submitted as the facility's credible allegation of compliance for all citations.	
F658 Services Provided Meet Professional Standards MO00248941	<p>The facility recognizes that all residents are affected by this deficient practice and will ensure compliance.</p> <p>Resident #1 has returned from the hospital and all orders have been reviewed, updated/transcribed properly, and are being followed.</p> <p>As of 03/11/25 Facility implemented use of ER checklist that includes family notifications, order transcription after visit, shift to shift reporting, and following orders. Fall incident checklist being used to properly investigate resident injuries.</p> <p>As of 03/11/25 All Licensed Clinical Staff Education has been completed on STAT order expectations, proper order transcription including ER visit orders, family notification, shift to shift reporting, proper documentation, and proper investigation of resident incident.</p> <p>The DON and/or designee will review all residents' ER visit and fall checklists within 24hrs of initiation of either checklists to ensure families are notified, orders are properly transcribed/clarified, documentation is appropriate, and injuries are investigated.</p> <p>The checklists will be further reviewed during clinical meetings M-F to ensure compliance.</p> <p>These checklists will be brought to QAPI to be reviewed by the IDT including the administrator and any concerns addressed immediately.</p> <p>The DON will keep the checklists for 12 months.</p>	03/11/25
F686 Treatments- Pressure Ulcer MO00249248	The facility recognizes that residents with similar conditions are affected by this deficient practice and will ensure compliance.	03/11/25

	<p style="text-align: center;">#4</p> <p>As of 03/11/25 Resident #2 treatment orders have been reviewed and treatment is being completed as ordered with proper documentation with heel protectors in place.</p> <p>All licensed clinical staff education has been completed as of 03/11/25 regarding following physician orders, treatment policy and procedures including reviewing orders prior to the completion and documentation of treatments. LPN G was provided one on one education and counseling.</p> <p>As of 03/11/25 the DON and/or designee audited all resident's treatment orders and observed each nurse complete dressing change.</p> <p>Starting 3/11/25 the DON and/or designee will complete (3) treatment observations weekly for (6) weeks then monthly for (3) months, then quarterly, and when necessary.</p> <p>These observations will be brought to QAPI to be reviewed by the IDT including the administrator and any concerns addressed immediately.</p>	
A4075 Nursing Care per Resident condition	See POC for F658	03/11/25
A4083 Pressure Sore Prevention	See POC for F686	03/11/25

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.

 Administrator
3/14/25