STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265735	A. Building B. Wing	06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Estates of Hidden Lake, The	11728 Hidden Lake Drive Saint Louis, MO 63138

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290 Based on interview and record review, the facility failed to ensure one resident (Resident #3) was free from abuse when staff failed to appropriately intervene and separate Residents #1 and #3 upon observation of the residents engaging in an increasingly agitated argument over Resident #3's walker. Resident #1 grabbed Resident #3's walker and pushed him/her to the ground, resulting in a fractured femur to Resident #3. The sample was four. The census was 51. Review of the facility's Abuse Prevention policy, undated, showed: -This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents. This will be done by: -Orienting and training employees on how to deal with stress and difficult situations, and how to recognize and report occurrences of abuse neglect, exploitation, and misappropriation of property; -Establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment; -Immediately protecting residents involved in identified reports of possible abuse, neglect, exploitation, mistreatment, and misappropriation of property; -This facility is committed to protecting our residents from abuse, neglect, exploitation, misappropriation of property and mistreatment by anyone including, but not limited to, facility staff, other residents, consultants, volunteers, staff from other agencies providing services to the individual, family members or legal guardians, friends, or any other individuals; -Orientation and Training of Employees: --During orientation of new employees, the facility will cover at least the following topics: (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-What constitutes abuse, neglect, exploitation, and misappropriation of resident property; -Dementia management and resident abuse prevention; -How to assess, prevent and manage aggressive, violent and/or catastrophic reactions of residents in a way that protects both residents and staff; -The policy failed to provide written guidance for staff on how to correct and intervene in situations in which abuse is more likely to occur. Review of Resident #1's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/26/24, showed: -Moderate cognitive impairment; -Behaviors not exhibited; -Diagnoses included Alzheimer's disease, dementia, and anxiety. Review of the resident's care plan, revised 5/24/24, showed: -Focus: Behavior: The resident is an elopement risk/wanderer related to history of attempts to leave facility unattended and impaired safety awareness; -Interventions include distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Distract resident by talking about his/her minister days and how God saved him/her. Talk about his/her boxing days and who he/she fought. -Focus: Resident has a behavior problem of verbal aggression; -Goal: Resident will not have a decline due to aggression until next review date; -Interventions included: Anticipate and meet the resident's needs. Caregivers to provide opportunity for positive interaction, attention. If reasonable, discuss the resident's behavior and explain/reinforce why behaviors are inappropriate and/or unacceptable to the resident. Monitor behavior episodes and attempt to determine underlying cause. Praise any indication of the resident's progress/improvement in behavior; -Focus: Resident is/has potential to be verbally aggressive related to dementia, ineffective coping skills, and poor impulse control; -Goal: Resident will have less than three episodes per day of verbal aggression through the review date; (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-Interventions included: Analyze key times, places, circumstances, triggers, and what de-escalates behavior and document. Assess resident's understanding of the situation and allow time for the resident to express self and feelings toward the situation. Monitor behaviors (specify frequency) and document observed behavior and attempted interventions. When the resident becomes agitated, intervene before agitation escalates, guide away from source of distress, engage calmly in conversation, and if response is aggressive, staff to walk calmly away and approach later. Review of the resident's nurse's note, dated 5/24/24 at 5:09 P.M., showed the resident was witnessed attempting to remove front-wheeled walker (FWW) from another resident. Resident then pushed the other resident before staff was able to intervene. Assessed at the time. Alert and oriented times one (to person). Increased aggression and agitation noted at the time. Non-compliant with redirection at the time, triggers unknown. Resident to be transported to hospital related to safety towards self and others, psychiatric evaluation, and treatment. Review of Resident #3's annual MDS, dated [DATE], showed: -Moderate cognitive impairment; -Use of walker; -Diagnoses included arthritis. Review of the resident's care plan, revised 5/24/24, showed the resident at risk for falls related to gait/balance problems, incontinence, wandering, and history of falls. Review of the resident's nurse's note, dated 5/24/24 at 5:00 P.M., showed the nurse documented he/she was made aware another resident was attempting to claim the resident's FWW. When he/she attempted to remove his/her FWW, the resident was pushed onto the floor before staff was able to intervene. Resident assessed at the time. Resident lying on left side, alert and oriented times one to two (to person and place) at times with periods of pleasant confusion noted. Complained of pain, voiced 10 out of 10 to left hip, left side of head noted. Call placed to emergency services related to transport to hospital. Review of the resident's hospital record, dated 5/28/24, showed the resident diagnosed with closed fracture (fracture with the skin intact) of neck of left femur (thighbone). Surgery performed on 5/26/24. During an interview on 6/4/24 at 11:24 A.M., Resident #3 said his/her hip was broken by Resident #1. The residents were in the dining room and when Resident #3 was standing up, Resident #1 snapped. He/She picked up Resident #3 and threw him/her down on the floor. Resident #3 was not sure why this happened. He/She went to the hospital and had surgery. He/She cannot walk right now and uses a wheelchair. During an interview on 6/4/24 at 1:28 P.M., Resident #1 said he/she did not have any issues with other residents. He/She denied hitting or pushing anyone. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 6/4/24 at 12:42 P.M., Certified Nurse Aide (CNA) I said Resident #1 has a history of verbal and physical aggression toward other residents and staff. On the day of the incident involving Residents #1 and #3, both residents were sitting on the couch in the sitting area next to the dining room. CNA I was walking other residents to the dining room for dinner and heard Residents #1 and #3 talking about Resident #3's walker. Resident #1 started getting angry, raising his/her voice and getting mad. As CNA I continued to walk residents to the dining room, he/she told Resident #1 the walker was not his/hers and told Resident #3 to move away from Resident #1. While Resident #3 tried to move away, Resident #1 stood up and tried to grab Resident #3's walker. CNA I saw this as he/she was walking with another resident, and again told Resident #1 the walker was not his/hers. Resident #1 hopped up in Resident #3's face and pushed Resident #3 hard, using both hands. Resident #3 fell on to the floor and started crying. The Certified Medication Technician (CMT) was also in the area passing medications at the time of the incident. Neither CNA I nor the CMT physically approached Residents #1 and #3 to intervene during the disagreement before Resident #1 pushed Resident #3. During an interview on 6/4/24 at 1:02 P.M., CMT E said on the day of the incident involving Residents #1 and #3, the residents were sitting on the couch in the sitting area next to the dining room. CMT E was passing medications at the cart in the dining room. He/She heard the residents getting agitated. Resident #1 was very, very agitated. He/She is a former boxer, so when he/she gets agitated, people can't get too close to him/her. The CNA who was walking by tried saying something to Resident #1. Resident #3 stood up and Resident #1 kept saying Resident #3's walker belonged to Resident #1. Resident #3 kept saying no, the walker belonged to him/her. Resident #1 grabbed the walker and Resident #3 pulled it back. CMT E turned his/her head toward the resident standing next to him/her at the medication cart, and when he/she turned back around, Resident #3 was on the ground with his/her head against the coffee table. Neither CMT E nor the CNA physically approached the residents to intervene during the disagreement, before Resident #3 was observed on the ground. Looking back at the incident, CMT E does not believe he/she could or should have done anything differently. Review of the facility's list of active employees and in-service trainings on resident to resident interactions, resident behavior, and cognitive impaired behaviors, provided on 5/30/24 and 6/4/24, showed: -74 staff employed by facility; -30 facility staff not documented as in attendance of in-service trainings; -CMT E not documented as in attendance of in-service trainings. During an interview on 6/4/24 at 4:31 P.M., Licensed Practical Nurse (LPN) C said he/she was working on the day of the incident involving Resident #1 and Resident #3, but he/she was in another resident's room and did not witness the altercation. The CNA informed LPN C of what occurred, and LPN C went to the sitting area and found Resident #3 on the floor, crying and hysterical. Staff said Resident #1 pushed Resident #3 after arguing over a walker. Resident #1 has dementia and can be aggressive toward other residents and staff. It is unknown what triggers him/her. He/She has dementia and likes to help with laundry and housekeeping tasks. Staff need to keep him/her busy with something before he/she gets triggered. Staff should redirect him/her as soon as he/she starts getting agitated. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 6/6/24 at 2:31 P.M., LPN J said Resident #1 likes to help staff and is easily redirected when given tasks he/she enjoys, like folding towels, sweeping, and wiping tables. Staff were expected to anticipate the resident's needs and observe his/her behavior. If they notice the resident is becoming anxious or agitated, they should intervene and redirect the resident. Staff should not wait for the resident to exhibit a behavior before they approach and redirect the resident. During an interview on 6/4/24 at 2:29 P.M., the Director of Nurses (DON) said Resident #1 is cognitively impaired and requires reality orientation. The DON has not seen the resident demonstrate the aggressive behaviors reported by staff. The resident sundowns (demonstrates increased confusion, restlessness, agitation, or irritability as night approaches) and the DON has observed at around 2:00 P.M., he/she jumps up and says he/she has to go to work. The DON is able to redirect him/her and finds the resident is easily redirectable. The resident likes to help clean things and likes working with his/her hands. He/She likes to sing, dance, and watch television, and he/she has preferred television shows. If staff are observing the resident being aggressive, they need to document their observations in the resident's record so she can try to look for what staff are seeing. She needs to see if the resident really has aggressive behaviors, or if staff are afraid of him/her because he/she was a boxer in the past. The resident feeds off staff's energy. Staff should respond to the resident in a calm manner. Administration has been doing in-service training with staff on resident behaviors and communication with residents who are cognitively impaired. During an interview on 6/4/24 at approximately 2:45 P.M., the Administrator said the facility is still relatively new for Resident #1. Prior to moving to the facility, the resident had a routine. Staff are still learning his/her patterns and behaviors, and trying to see what works and what doesn't when addressing him/her. They identified that the resident likes snacks and likes to help staff clean. He/She seemed more relaxed when sitting in one of the chairs in the sitting area, rather than on the couch. He/She did not respond well to overstimulation or people talking to him/her aggressively. Staff seem like they are afraid of the resident. It could be that his/her behavior was exacerbated by staff's response to him/her. During her investigation, the Administrator found that when Residents #1 and #3 started arguing, there was an opportunity where staff should have physically intervened and immediately separated the residents when they started getting agitated. When a resident becomes agitated or exhibits behaviors, the Administrator expected staff to redirect the resident using the identified interventions. MO00236799

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290 Based on interview and record review, facility staff failed to follow the facility's policy to immediately notify the Administrator of a physical altercation involving two residents (Residents #1 and #4) after Resident #1 demonstrated physical aggression toward Resident #4, and facility staff failed to report the incident to the residents' physicians and responsible parties. The failure to notify the Administrator resulted in a delayed investigation and delayed implementation of interventions to prevent further incident. The following day, Resident #1 went back to the room of Resident #4 and exhibited physical aggression requiring staff intervention. The sample was four. The census was 51. Review of the facility's Abuse Prevention policy, undated, showed: -This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents. This will be done by: -Orienting and training employees on how to deal with stress and difficult situations, and how to recognize and report occurrences of abuse neglect, exploitation, and misappropriation of property; -Immediately protecting residents involved in identified reports of possible abuse, neglect, exploitation, mistreatment, and misappropriation of property; -Orientation and Training of Employees: --During orientation of new employees, the facility will cover at least the following topics: -What constitutes abuse, neglect, exploitation, and misappropriation of resident property; -Procedures for reporting incidents/allegations of abuse, neglect, exploitation or the misappropriation of resident property; -Internal Reporting Requirements and Identification of Allegations: --Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about, or suspect to the Administrator immediately, to an immediate supervisor who must then immediately report it to the Administrator or to a compliance hotline or compliance officer. In the absence of the Administrator, reporting can be made to an individual who has been designated to act in the Administrator's absence; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Supervisors shall immediately inform the Administrator or person designated to act in the Administrator's absence of all reports of incidents, allegations or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property. Upon learning of the report, the Administrator or a designee shall initiate an incident investigation; -Any allegation of abuse or any incident that results in serious bodily injury will be reported to the State Department of Public Health immediately, but not more than two hours of the allegation of abuse. Any incident that does not involve abuse and does not result in serious bodily injury shall be reported within 24 hours; -The resident's physician and representative, if necessary, shall be notified of any incident or allegation of abuse, neglect, exploitation, mistreatment or misappropriation of resident property. -Protection of Residents --The facility will take steps to prevent potential abuse while the investigation is underway. -Residents who allegedly abused another resident shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement, considering his or her safety, as well as the safety of other residents and employees of the facility. In addition, the facility shall take all steps necessary to ensure the safety of residents including, but not limited to, the separation of the residents; -Internal Investigation: -All incidents will be documented, whether or not abuse, neglect, exploitation, mistreatment or misappropriation of resident property occurred, was alleged or suspected; -Any incident or allegation involving abuse, neglect, exploitation, mistreatment or misappropriation of resident property will result in an investigation; -External reporting: --Initial Reporting of Allegations. When an allegation of abuse, exploitation, neglect, mistreatment or misappropriation of resident property has been made, the administrator, or designee, shall notify Department of Public Health's regional office immediately by telephone or fax. Public Health shall be informed that an occurrence of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property has been reported to the administrator and is being investigated; --This report shall be made immediately; --The resident or resident's representative will also be immediately informed of the report of an occurrence of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property and that an investigation is being conducted; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--The term immediately as it is used in this policy in relation to reporting abuse, neglect, exploitation, mistreatment, misappropriation of resident property, and suspicion of a crime shall be defined as, following management of the immediate risk to the resident or residents, including the administration of necessary medical attention, and establishing the safety of the resident or residents involved or not later than two hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause suspicion do not result in serious bodily injury. Review of Resident #1's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/26/24, showed: -Moderate cognitive impairment; -Behaviors not exhibited; -Diagnoses included Alzheimer's disease, dementia, and anxiety. Review of the resident's care plan, revised 5/24/24, showed: -Focus: Resident has a behavior problem of verbal aggression; -Goal: Resident will not have a decline due to aggression until next review date; -Interventions included monitor behavior episodes and attempt to determine underlying cause; -Focus: Resident is/has potential to be verbally aggressive related to dementia, ineffective coping skills, and poor impulse control; -Goal: Resident will have less than three episodes per day of verbal aggression through the review date; -Interventions included: Analyze key times, places, circumstances, triggers, and what de-escalates behavior and document. Monitor behaviors (specify frequency) and document observed behavior and attempted interventions. Review of the resident's progress note, dated 6/3/24 at 12:59 P.M., showed: -Staff documented behavior observed. Resident observed entering another resident's room. Redirected with compliance noted at the time. Separated, at lunch table eating lunch at this time with no agitation or aggression noted. Will communicate in report; -The progress note did not indicate physical aggression demonstrated toward the other resident or staff. The progress note did not indicate the resident's physician or responsible party was notified. Review of the Resident #4's annual MDS, dated [DATE], showed: -Severe cognitive impairment; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Lower extremity impairment on both sides; -Use of wheelchair; -Substantial/maximal assistance required for sit to stand and chair/bed-to-chair transfer; -Walking not attempted due to medical condition of safety concerns; -Diagnoses included arthritis, hemiplegia (paralysis on one side of the body) or hemiparesis (weakness on one side of the body), seizures, aphasia (language impairment), dementia, anxiety, depression, and psychotic disorder (mental disorders that cause abnormal thinking and perceptions). Review of the resident's medical record, showed no documentation regarding another resident attempting to hit him/her on 6/3/24. During an interview on 6/4/24 at 10:45 A.M., Resident #4 said yesterday, another resident was in his/her room trying to hit people. An employee was in the room at the time. Resident #4 did not know why the other resident was trying to hit people. He/She was afraid of the other resident. He/She felt safe in the facility, but was scared of the other resident. During an interview on 6/4/24 at 10:20 A.M., Restorative Aide (RA) B said Resident #1 is aggressive and has a history of beating up other residents. Nursing management was aware of these behaviors, but won't do anything about it. Yesterday, Resident #1 went into Resident #4's room and blocked Certified Nurse Aide (CNA) A in there. Resident #1 was trying to hit Resident #4 while CNA A was in between the two residents. During an interview on 6/4/24 at 10:40 A.M., RA H said he/she worked day shift yesterday, but did not work on the unit with Residents #1 and #4. He/She heard that during the shift, Resident #1 went after Resident #4, swinging on him/her while the CNA was in between the residents to block Resident #1 from hitting Resident #4. Resident #4 has a hard time expressing some words, but he/she is alert and knows what is going on. During an interview on 6/4/24 at 11:06 A.M., CNA A said yesterday, he/she entered the room of Resident #4 to deliver a lunch tray to the resident's roommate. Resident #4 was in the room at the time. While delivering the lunch tray, CNA A turned around and saw Resident #1 enter the room and close the door behind him/her. Resident #4 told Resident #1 it was not his/her her room. Resident #1 started swinging at Resident #4. Resident #1 was swinging his/her fist upward in order to hit Resident #4, who was seated in his/her wheelchair. CNA A quickly moved Resident #4's wheelchair back before Resident #1 could make contact. Resident #1 picked up a tote and tried to throw it. He/She kept swinging at Resident #4 while CNA A stood between them, yelling for help. Resident #1 exited the room and other staff came to the door, asking what happened. One of the management staff talked to CNA A about the incident, but CNA A could not identify the management staff due to being a newer employee to the facility. During an interview on 6/4/24 at 1:28 P.M., Resident #1 said he/she did not have any issues with other residents. He/She denied hitting or pushing anyone. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/4/24 at 1:33 P.M., CNA G said yesterday, Resident #1 went into Resident #4's room, closed the door, and was swinging on Resident #4. An hour ago, Resident #1 went into Resident #4's room again and Resident #4 was yelling. Licensed Practical Nurse (LPN) C went to the room and Resident #1 swung on him/her. Other staff responded and got Resident #1 out of the room. Resident #4 is scared of the other resident and said Resident #1 was trying to kill him/her. Resident #1 has not been on increased monitoring today. During an interview on 6/4/24 at 1:48 P.M., Resident #4 said Resident #1 tried to hit him/her again today. Resident #4 was on the toilet in his/her room when it happened. The nurse got involved and Resident #1 charged at the nurse and tore his/her glasses off. During an interview on 6/4/24 at 1:54 P.M., Certified Medication Technician (CMT) D said he/she worked day shift yesterday. Yesterday, Resident #1 went into Resident #4's room and lashed out to him/her. CMT D did not see this happen, but heard about it from CNA A, who was in Resident #4's room when it happened. Resident #1 was not on increased monitoring after the incident. Earlier today, there was hollering that Resident #1 was back in Resident #4's room. CMT D ran down to the room and LPN C was blocking Resident #1 from entering the room. Resident #1 was trying to get at Resident #4 and hit the nurse. The Director of Nurses (DON) came to the room and Resident #1 was brought out to the sitting area by the dining room. Resident #1 is currently on 15-minute checks, where staff have to keep an eye on him/her every 15 minutes. The resident can be unsupervised in between the 15-minute checks. During an interview on 6/4/24 at 4:31 P.M., LPN C said yesterday, he/she was sitting at the nurse's station around lunchtime when CNA A came to him/her and said Resident #1 went into Resident #4's room, throwing punches at Resident #4, and CNA A had to dodge a bunch of shots. LPN C documented the incident in Resident #1's record as a behavior, but did not document the incident in Resident #4's record. LPN C reported the incident to the DON. Resident #1 was not placed on increased monitoring. Earlier today, LPN C was in Resident #4's room assisting him/her to the toilet. LPN C was going to step out to give the resident some privacy and when he/she opened the door to leave, Resident #1 was standing in the doorway. LPN C attempted to close the door, but Resident #1 got halfway inside and struck at LPN C. LPN C told the DON about the incident. When an incident like this occurs, the nurse is responsible for charting on it and notifying the physician, family, and management. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265735	A. Building B. Wing	06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Estates of Hidden Lake, The	11728 Hidden Lake Drive Saint Louis, MO 63138

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/4/24 at approximately 2:40 P.M., the DON and Administrator were asked if they were aware of an incident occurring on 6/3/24 involving Resident #1 and Resident #4. The DON would not answer the question about her knowledge of the incident. The Administrator said she was not aware of the incident. The Administrator said earlier today, she heard CNA A speaking loudly on the unit. The Administrator went to the unit and saw LPN C exiting Resident #4's room, stating someone hit him/her. The Administrator instructed LPN C to fill out an incident report. No one notified the Administrator that Resident #1 was trying to hit Resident #4. Anytime a resident becomes physically aggressive toward another resident, it should be reported to management, including the Administrator. The nurse should notify the physician and family for both residents. The nurse should get statements, check on other residents, see if other people can corroborate the details, and initiate onsite interventions. If Resident #1 attempted to hit Resident #4 yesterday, the nurse should have initiated 15-minute checks. Resident #1 has not been on 15-minute checks today. The Administrator should have been notified of the incident. She needs to be made aware of incidents of abuse or attempted abuse so she can investigate. There are cameras throughout the facility and it would be helpful to review surveillance footage during an abuse investigation, but the Administrator does not have access to the surveillance footage.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290 Based on in interview and record review, the facility failed to ensure staff consistently documented and detailed specific behaviors exhibited by one resident with dementia who displayed psychosocial adjustment difficulty (Resident #1). This failure resulted in insufficient information available for consideration by the interdisciplinary team (IDT) when determining resident-specific non-pharmacological interventions to address the resident's behaviors and to assist the resident in attaining his/her highest practicable mental and psychosocial well-being. The facility failed to ensure psychosocial follow-up was provided to one resident (Resident #3) who expressed feelings of fearfulness following an incident in which his/her femur was fractured when another resident (Resident #1) pushed him/her down. The sample was 4. The census was 51. Review of the facility's Problematic Behavior Management policy, revised August 2008, showed: -Identify individuals with a history of impaired cognition (for example, dementia), problematic behavior, or mental illness; -The staff will identify, document, and inform the physician about an individual's mental status, behavior, and cognition; -This will include details about any problematic behavior such as onset, frequency, and precipitating factors; -Nursing staff will document the nature, duration, and associated features of any changes over time in behavior, cognition, or mood; -The staff will use protocols to identify pertinent interventions, other than medications, for the nature and causes of the individual's problematic behavior. 1. Review of Resident #1's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/26/24, showed: -admitted [DATE]; -Moderate cognitive impairment; -Behaviors not exhibited; -Diagnoses included Alzheimer's disease, dementia, and anxiety. Review of the resident's nurse order administration notes and progress notes, showed: -On 4/4/24 at 4:32 A.M., behavior observed. No additional information; (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 4/5/24 at 8:21 P.M., behavior observed. No additional information; -On 4/5/24 at 11:43 P.M., behavior observed. No additional information;. -On 4/7/24 at 8:21 P.M., behavior observed. No additional information; -On 4/8/24 at 12:22 A.M., behavior observed. No additional information; -On 4/9/24 at 4:15 A.M., behavior observed. No additional information; -On 4/12/24 at 1:08 A.M., behavior observed. No additional information; -On 4/18/24 at 12:10 A.M., behavior observed. No additional information; -On 4/20/24 at 12:08 P.M., behavior observed. No additional information; -On 4/24/24 at 9:48 P.M., behavior observed. No additional information; -On 4/25/24 at 12:46 A.M., behavior observed. No additional information; -On 4/25/24 at 10:14 P.M., behavior observed. No additional information; -On 4/26/24 at 2:50 A.M., behavior observed. No additional information; -On 4/26/24 at 5:30 P.M., behavior observed. No additional information; -On 5/4/24 at 6:36 P.M., behavior observed. No additional information; -On 5/7/24 at 12:01 A.M., behavior observed. No additional information; -On 5/8/24 at 9:56 P.M., behavior observed. No additional information; -On 5/9/24 at 2:18 A.M., behavior observed. No additional information; -On 5/9/24 at 8:57 P.M., behavior observed. No additional information; -On 5/10/24 at 12:43 A.M., behavior observed. No additional information; -On 5/11/24 at 6:47 A.M., behavior observed. No additional information; -On 5/22/24 at 6:44 A.M., behavior observed. No additional information; -On 5/22/24 at 7:55 P.M., behavior observed. No additional information. Review of the resident's Certified Nurse Aide (CNA) behavior charting from April and May 2024, showed no behaviors documented. Review of the resident's care plan, revised 5/24/24, showed: (continued on next page)

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	265735	A. Building B. Wing	06/04/2024

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Focus: Behavior: the resident is an elopement risk/wanderer related to history of attempts to leave facility unattended and impaired safety awareness; -Interventions include distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Resident prefers: Distract resident by talking about his/her minister days and how God saved him/her. Talk about his/her boxing days and who he/she fought; -Focus: Resident has a behavior problem of verbal aggression; -Goal: Resident will not have a decline due to aggression until next review date; -Interventions included: Anticipate and meet the resident's needs. Caregivers to provide opportunity for positive interaction, attention. If reasonable, discuss the resident's behavior and explain/reinforce why behaviors are inappropriate and/or unacceptable to the resident. Monitor behavior episodes and attempt to determine underlying cause. Praise any indication of the resident's progress/improvement in behavior; -Focus: Resident is/has potential to be verbally aggressive related to dementia, ineffective coping skills, and poor impulse control; -Goal: Resident will have less than three episodes per day of verbal aggression through the review date; -Interventions included: Analyze key times, places, circumstances, triggers, and what de-escalates behavior and document. Assess resident's understanding of the situation and allow time for the resident to express self and feelings toward the situation. Monitor behaviors (specify frequency) and document observed behavior and attempted interventions. When the resident becomes agitated, intervene before agitation escalates, guide away from source of distress, engage calmly in conversation, and if response is aggressive, staff to walk calmly away and approach later. During an interview on 6/4/24 at 10:20 A.M., Restorative Aide (RA) B said the resident is aggressive and has a history of beating up other residents. He/She goes into the rooms of other residents. In one incident, he/she broke another resident's fingernails. Yesterday, he/she went into a different resident's room and tried to hit the other resident. It is unknown what triggers the resident's behaviors and staff are still trying to figure out what calms him/her down. RA B approaches the resident by talking to him/her from the side and the resident has always been calm toward him/her. During an interview on 6/4/24 at 11:06 A.M., Certified Nurse Aide (CNA) A said he/she has worked with the resident for about a week. Yesterday, CNA A was passing lunch trays when Resident #1 entered the room of another resident and started swinging at the resident. Resident #1 seems triggered when he/she feels like someone is lying to him/her. It is unknown what calms him/her down. It is hard to watch him/her. Nurses do behavior charting on residents. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/4/24 at 12:42 P.M., CNA I said the resident has a history of verbal and physical aggression toward other residents and staff. He/She hopped up in another resident's face and pushed him/her down. He/She yells at other residents and wanders into other resident rooms. CNA I just keeps his/her distance from the resident. When he/she sees the resident wandering, he/she tries to redirect the resident. He/She tries to keep other residents away from Resident #1. He/She is unsure of how else to redirect the resident. He/She is not sure what the resident's triggers are or what helps calm him/her down. Nurses do the behavior charting on residents. During an interview on 6/4/24 at 1:02 P.M., Certified Medication Technician (CMT) E said the resident is a former boxer, so when he/she gets agitated, people can't get too close to him/her. CMT E observed the resident argue with another resident over a walker. Next thing CMT E knew, the other resident was on the ground. Prior to this incident, the resident had no history of aggression of which CMT E was aware. Since the incident, CMT E has not been informed of any new approaches or interventions to take with the resident. During an interview on 6/4/24 at 1:33 P.M., CNA G said the resident is very aggressive. An hour ago, he/she went into another resident's room and swung on staff. He/She tries to attack other residents and nothing diffuses him/her. When he/she gets in another resident's face, staff are supposed to be firm when speaking with him/her and approach him/her at an angle, but that doesn't work because the resident is still in attack mode. It seems like visits with his/her spouse trigger him/her and then he/she is ready to strike. CNAs report behaviors and incidents of aggression to the nurses. During an interview on 6/4/24 at 1:54 P.M., CMT D said yesterday, the resident went into another resident's room and lashed out at him/her. Earlier today, there was hollering. Resident #1 was back in the other resident's room and was trying to hit the nurse. CMT D has no clue what triggers the resident or what interventions effectively address his/her behavior. The resident has always been sweet to him/her. During an interview on 6/4/24 at 4:31 P.M., Licensed Practical Nurse (LPN) C said the resident is physically aggressive toward other residents and staff. There is nothing in particular that sets him/her off. He/She has dementia and he/she is unpredictable. He/She goes out to the hospital frequently for behaviors, but keeps being sent to a hospital that does not have a psych department and then ends up back at the facility with no medication changes. Nursing staff is supposed to chart on resident behaviors and they should specify what the behaviors were. During an interview on 6/4/24 at 4:16 P.M., LPN F said he/she pulled the behavior charting from the resident's electronic medical record (EMR). No behaviors were documented in the CNA behavior charting. In the behavior charting screens, it allows staff to choose the specific type of behaviors exhibited by the resident. He/She uses the behavior charting from all nursing staff when he/she completes the behavior portion of the resident MDS. He/She also assists with updating care plans. The IDT meets every morning and they discuss and determine resident-specific interventions. Once an intervention is identified, it is added to the resident's care plan. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #'1's nurse's note, dated 5/24/24 at 5:09 P.M., showed resident was witnessed attempting to remove front-wheeled walker (FWW) from another resident. Resident then pushed the other resident before staff was able to intervene. Assessed at the time. Alert and oriented times one (to person). Increased aggression and agitation noted at the time. Non-compliant with redirection at the time, triggers unknown. Resident to be transported to hospital related to safety towards self and others, psych evaluation, and treatment. Review of the resident's Social Services (SS) evaluation, dated 5/30/24, showed: -Reason for evaluation: Admission/readmission; -Information source: Resident; -Ability to express ideas and wants: Sometimes understood; -Change in cognitive status (within last six months): Deteriorated; -Does the resident have history of or current episodes of or risk of the following: -Physical behaviors toward others: Not checked; -Verbal behavior toward others: Not checked; -Other behavior symptoms not directed toward others: Not checked; -Wandering: Not checked; -Behavior care plan: Not checked; -Signed by Social Services Director (SSD). Review of the resident's medical record, showed no further documentation from SSD following incident on 5/24/24. Review of the resident's care plan, revised 6/4/24, showed: -Focus: Resident has a behavior problem of verbal and physical aggression; -Goal: Resident will not have a decline due to aggression until next review date; -The care plan failed to identify the resident engaging in a physical altercation with another resident on 5/24/24, resulting in a serious injury to the other resident. 2. Review of Resident #3's annual MDS, dated [DATE], showed: -Moderate cognitive impairment; -Use of walker; (continued on next page)

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	265735	A. Building B. Wing	06/04/2024

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses included arthritis. Review of the resident's nurse's note, dated 5/24/24 at 5:00 P.M., showed the nurse documented he/she was made aware another resident was attempting to claim the resident's FWW. When he/she attempted to remove his/her FWW, the resident was pushed onto the floor before staff was able to intervene. Resident assessed at the time. Resident lying on left side, alert and oriented times one to two (to person and place) at times with periods of pleasant confusion noted. Complained of pain, voiced 10 out of 10 to left hip, left side of head noted. Call placed to emergency services related to transport to hospital. Review of the resident's hospital record, dated 5/28/24, showed the resident diagnosed with closed fracture (fracture with the skin intact) of neck of left femur. Surgery performed on 5/26/24. Review of the resident's SS evaluation, dated 5/30/24, showed: -Reason for evaluation: Admission/readmission; -Ability to express ideas and wants: Understood; -Does the resident have a history of traumatic event(s) which the facility needs to take into consideration when developing the resident's plan of care: Yes; -If yes, describe traumatic event, possible triggers for resident, and interventions implemented on behalf of the resident: Resident mentioned he/she thought he/she would die at an early age; -Post-traumatic stress/trauma informed care plan: Blank; -Does the resident have any mental health concerns/issues: No. Review of the resident's medical record, showed no further documentation from SSD following the incident on 5/24/24. Review of the resident's care plan, revised 6/4/24, showed: -Focus: Resident has limited physical mobility related to weakness and recent hip fracture; -Interventions included provide supportive care, assistance with mobility as needed; -Focus: Resident has pain related to osteoarthritis and hip fracture; -The care plan failed to identify the cause of the fracture due to being pushed to the floor by another resident, and to identify the resident's fearfulness of the other resident and being left alone, with interventions to support the resident's psychosocial well-being. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/4/24 at 11:24 A.M., Resident #3 said his/her hip was broken by Resident #1. The residents were in the dining room and when Resident #3 was standing up, Resident #1 snapped. He/She picked up Resident #3 and threw him/her down on the floor. Resident #3 was not sure why this happened. He/She went to the hospital and had surgery. He/She cannot walk right now and uses a wheelchair. He/She is scared of Resident #1 and feels unsafe around him/her. Resident #3 does not want to be left alone without other people around anymore. The resident became tearful when talking about being scared. During an interview on 6/4/24 at 1:28 P.M., Resident #1 said he/she did not have any issues with other residents. He/She denied hitting or pushing anyone. 3. During an interview on 6/4/24 at 2:03 P.M., the SSD said she started working with the facility on 4/8/24. She is not too familiar with Resident #1 and is still getting to know him/her. She met with the resident during her first week of employment to introduce herself. On 5/24/24, Resident #1 pushed Resident #3 down, resulting in a fracture to Resident #3. The SSD did not work on the day of the occurrence, but heard about it the next day. She was not asked to complete an assessment on either resident. She completed routine SS evaluations on both residents on 5/30/24. Resident #1 was unable to answer most questions, so SSD got most of the information from the resident's family member. For SS evaluations, she also talks to nursing staff about the residents. The SS evaluation should reflect the resident's status at the time of assessment. She was not aware Resident #1 was having ongoing behaviors. She was aware of the incident on 5/24/24, but did not know about any other incidents of physical aggression. She wants to be notified of such occurrences so she can have a conversation with the resident and assist in determining interventions. If made aware of the resident's behaviors, she would want to try to see what triggers the resident and would consider having weekly or biweekly meetings with the resident. Or, she would consider linking him/her to counseling services through an outside agency. After the incident on 5/24/24, Resident #3 was sent out to the hospital. SSD met with the resident when he/she returned to the facility and he/she seemed fine. SSD has not met with Resident #3 since then. She was not aware Resident #3 had feelings of fearfulness following the incident with Resident #1. 4. During an interview on 6/4/24 at 2:29 P.M., the Director of Nurses (DON) said she knew Resident #1 from his/her previous placement in the other building on the facility's campus. The resident was pleasantly confused. He/She thought he/she worked at the facility and wanted to help out. He/She is cognitively impaired and requires reality orientation. He/She moved to his/her current placement a couple of months ago. Nursing staff reports the resident exhibits physically aggressive behavior. The DON has not seen the resident demonstrate the aggressive behaviors reported by staff. The resident sundowns (demonstrates increased confusion, restlessness, agitation, or irritability as night approaches) and the DON has observed at around 2:00 P.M., he/she jumps up and says he/she has to go to work. The DON is able to redirect him/her and finds the resident is easily redirectable. The resident likes to help clean things and likes working with his/her hands. He/She likes to sing, dance, and watch television, and he/she has preferred television shows. If staff are observing the resident being aggressive, they need to document their observations in the resident's record so she can try to look for what staff are seeing. She needs to see if the resident really has aggressive behaviors, or if staff are afraid of him/her. Administration has been doing in-service training with staff on resident behaviors and communication with residents who are cognitively impaired. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. During an interview with the DON and Administrator on 6/4/24 at approximately 2:40 P.M., the Administrator said the facility is still relatively new for Resident #1. Prior to moving to the facility, the resident had a routine. Staff are still learning his/her patterns and behaviors, and trying to see what works and what doesn't when addressing him/her. They have identified that the resident likes snacks and likes to help staff clean. He/She seems more relaxed when sitting in one of the chairs in the sitting area, rather than on the couch. He/She does not respond well to overstimulation or people talking to him/her aggressively. Staff seem like they are afraid of the resident. It could be that his/her behavior is exacerbated by staff's response to him/her. The resident has had some adjustments to his/her psychotropic medications since he/she was admitted to the facility. When the incident occurred on 5/24/24, the resident was supposed to go out to a hospital with a psychiatric department for a possible medication reconciliation, but he/she was sent to a different hospital instead, and then returned to the facility. When he/she came back to the facility, staff should have had the resident sent back out to the other hospital with the psychiatric department for the medication reconciliation. When the Administrator started investigating the incident on 5/24/24, she became more aware of the ongoing behaviors exhibited by the resident. The full extent of his/her behaviors had not been reported to her before this. She started looking into the resident's medications, the times of events, and who was involved during the events. The documentation of behaviors lack detail surrounding some behaviors and the DON and Administrator expect nursing staff to be more descriptive when charting behaviors. Descriptive notes on behaviors are necessary for the IDT to identify triggers and resident-specific non-pharmacological interventions. Identified interventions should be reflected on the resident's care plan. The SSD should be involved and she needs to know about the resident's behaviors so she can focus on person-centered care and education with staff. Documentation of specific behaviors would also be helpful in determining whether or not the facility is an appropriate placement for the resident. Following the incident on 5/24/24, the SSD should have followed up with Resident #3. The Administrator was not aware Resident #3 expressed fearfulness following the incident and it is expected that he/she receive follow-up to address his/her concerns. She expects SS evaluations to be completed accurately and to indicate the resident's status at the time of assessment.