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	08/19/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35394 37672 50366 Based on observation, interview and record review, the facility failed to provide a safe, clean, comfortable, and homelike environment. The facility had two floors in which residents resided. Lighting issues were identified in the first-floor spa room and men's restroom. The dining room on the first floor had chipped paint and duck-tape on the floor. One resident (Resident #23) had torn drywall and an unfinished ceiling in the bathroom. In addition, 12 additional resident rooms had a variety of environmental concerns. The sample was 14. The census was 53. Review of the facility's Nursing Home Residents' Rights, provided to residents upon admission to the facility, showed: -No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the United States solely on account of his or her status as a resident of the Community; -The right to live in an environment that promotes and supports each resident's dignity, individuality, independence, self-determination, privacy, and choice and to be treated with consideration and respect. 1. Observations on 8/14/24 at 8:30 AM and 8/16/24 at 7:33 AM, showed: The spa room, located on Spring Garden Hall, had two out of the three sets of lights, with double fluorescent light bulbs going out and not bright and only gave off a dim pink color. Observations on 8/14/24 at 8:36 AM and 8/16/24 at 8:05 AM, showed: The men's restroom, located on the first floor off the dining room, was dark and had no working light fixtures. During an interview on 8/16/24 at 7:45 AM, Certified Nursing Assistant (CNA) G said the lights in the spa room and men's restroom have been out for a while. It was reported to maintenance. During an interview on 8/15/24 at 7:00 AM, Licensed Practical Nurse (LPN) I said he/she was not aware the men's restroom light does not work (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Observation on 8/16/24 at 7:33 AM, showed: The dining area and halls on the first floor had numerous areas in need of paint touch up. The area around a door that goes outside off the dining room has paint that buckled and chipped off. In the combined dining and activity area there was baseboard trim missing and an area of grey duct-tape, peeled up from the dining room floor that lead to the halls and resident activity area. 3. Observation on 8/13/24 at 7:26 A.M., of Resident #23's bathroom, showed the bathroom drywall torn, ripped and unfinished at the ceiling. LPN I said the bathroom wall had been in disrepair for months. He/She did not know if the maintenance staff were aware of the issue. He/She was not aware who to report maintenance issues or repair needs to. He/She would report issues to the Director of Nursing (DON). 4. Observations on 8/12/24 at 1:50 PM, 8/14/24 at 8:51 AM, and 8/16/24 8:04 at AM, showed: Resident room [ROOM NUMBER], double occupancy room, had a very strong odor of urine and was in need of paint touch up. 5. Observation and interview on 8/13/24 at 7:26 AM, showed: Resident room [ROOM NUMBER] restroom had drywall torn, ripped and unfinished at the ceiling. Licensed Practical Nurse (LPN) I said the restroom wall had been in disrepair for months. He/She did not know if the maintenance staff were aware of the issue. He/She was not aware who to report maintenance issues or repair needs to. He/She would report issues to the DON. Observations on 8/14/24 at 8:41 AM and 8/16/24 at 8:03 AM, showed: Resident double occupancy room [ROOM NUMBER], with a very strong odor of urine. The resident's area on the right side of room was missing the privacy curtain. In the resident's restroom, the light cover over the vanity fixture was missing and exposed two fluorescent light bulbs. 6. Observation on 8/14/24 at 8:40 AM, showed: Resident room [ROOM NUMBER], had no light cover over the vanity fixture that exposed two fluorescent light bulbs with one bulb not working. The paint on the wall around the air-conditioner chipped off with white patches of drywall exposed. Drywall torn, ripped, and unfinished at the ceiling with an opening approximately 3 feet in length and a half an inch wide, where the wall and the ceiling meet. 7. Observation on 8/14/24 at 8:46 AM, showed: Resident double occupancy room [ROOM NUMBER], with the light cover over the vanity fixture missing and exposed two fluorescent light bulbs with one light bulb not working. The brown wall on the left side of the room around the call light connection had patches of white in was need of paint. 8. Observation on 8/14/24 at 8:51 AM, showed: Resident double occupancy room [ROOM NUMBER], the restroom had a dirty laundry container that overflowed with dirty clothes onto the floor next to the commode. In front of the commode was a black, anti-slip coating peeled off with ragged edges. 9. Observation on 8/16/24 at 7:34 AM, showed: Resident room [ROOM NUMBER], the right side of room with white marks in need of paint touch up. 10. Observation on 8/16/24 at 7:36 AM, showed: Resident double occupancy room [ROOM NUMBER], with areas on the wall around the corners and scattered around the room in need of paint touch up. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11. Observation on 8/16/24 at 7:39 AM, showed: Resident double occupancy room [ROOM NUMBER], did not have individual privacy curtains for the beds in the room. 12. Observation and interview on 8/16/24 at 7:40 AM, showed: Resident double occupancy room [ROOM NUMBER], had multiple scattered areas on the wall in need of paint touch up and the light in the restroom not working. LPN G said the light has been out for at least two weeks and he/she has told maintenance about it a couple times. The residents in the room are confused. 13. Observation on 8/16/24 at 7:41 AM, showed: Resident double occupancy room [ROOM NUMBER], restroom fluorescent light was very dim. The residents in the room were unable to be interviewed. 14. During an observation on 8/16/24 at 7:42 AM, showed: Resident double occupancy room [ROOM NUMBER], had wall repairs completed around the air conditioner in need of touch up paint. 15. During an interview on 8/12/24 at 11:56 A.M., Resident #304 said the carpet is an issue for him/her. The carpets in the hallway and outside the nurse's station and dining room are dirty and stained. 16. During an interview with the resident council, on 8/14/24 at 1:48 P.M., Resident #5, said his/her blinds were worn. Maintenance said he/she was not able to receive new blinds. He/She could not remember the reason. 17. During an interview on 8/16/24 at 12:56 PM, the DON said all rooms should have privacy curtains in them. She was not aware of all the lights being out, strong urine odor in rooms #121 and #124, privacy curtains missing in rooms #124 and #122, duct tape on floor in dining and activity area, and walls needing repairs and painting. Staff are responsibility to fill out a maintenance form, available at all nursing stations, when repairs are needed and give it to the maintenance department or to her so she can give it to them during the morning meeting. All fluorescent light fixtures should have covers over them and the carpets in the rooms with strong urine odor need to be shampooed. 18. During an interview on 8/16/24 at 1:10 PM, the Administrator said all rooms should have privacy curtains. She was not aware of all the lights being out, strong urine odor in rooms, privacy curtains missing in rooms #124 and 122, duct tape on the floor in dining and activity area, and walls needing repairs and painting. All the resident's equipment, clothes and the room's carpet needs to be checked and cleaned to see where the urine odor is coming from. She will check with housekeeping. 19. During an interview on 8/16/24 at 11:32 AM, the Housekeeping Supervisor (HKS) said she has only been in the position for three weeks but has been working at the facility for [AGE] years in various jobs. She is aware of the strong urine odor in rooms #121 and #124 and said it is down deep in the carpet. She has started a deep cleaning program, and these rooms are on the list. NOTE TO REVIEWER - No resident interviews about the resident room examples or common area examples except for the one about the carpets. MP

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 44950 Based on observation, interview, and record review, the facility failed to follow their grievance policy for one sampled resident (Resident #43). The facility failed to provide prompt resolution of Resident #43's grievance regarding the family member's concern of how the resident was transferred. The facility did not follow up on the grievance recommendation to resolve the issue by therapy evaluating the resident to determine the correct device for transferring. The sample was 22. The census was 51. Review of the facility's grievance policy, undated, showed: -Policy: The facility will assist residents, their representatives such as, other interested family members or other resident advocates in filing grievances or complaints when such requests are made; -Policy Specifications: -1. Any resident, their representative, family member, or other advocate may file a grievance or complaint concerning treatment, medical care, behavior of other residents, staff members, theft of property, etc., without fear of threat or reprisal in any form. -2. Upon admission, residents are provided with written information on how to file a grievance or complaint. A copy of the facility's grievance/complaint procedures is posted in prominent locations throughout the facility. -3. Grievance postings will include the contact information of the grievance official including name, business address, e-mail, and phone number. A copy of this grievance policy will be given upon request. The facility Administrator is the designated grievance official. -4. Grievances and/or complaints may be submitted orally or in writing. Written complaints or grievances must be signed by the resident or the person filing the grievance or complaint on behalf of the resident. -5. The administrator may delegate investigation of the grievance to the relevant individual or department head. -6. Upon receipt of a written grievance and/or complaint, the designated individual will investigate the allegations and submit a written report of such findings to the administrator within 5 working days of receiving the grievance and/or complaint. -7. The administrator will review the findings with the person investigating the complaint to determine what corrective actions, if any, need to be taken. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-8. The resident, or person filing the grievance and/or complaint on behalf of the resident including grievances filed anonymously, will be informed of the findings of the investigation and the actions that will be taken to correct any identified problems. Such report will be made orally by the administrator, or his or her designee, within 5 working days of the filing of the grievance or complaint with the facility. A written decision of the report will also be provided upon request, and a copy will be filed in the business office. -9. Consistent with 483.12(c)(1), by anyone furnishing services on behalf of the provider, all alleged violations involving neglect, abuse, including injuries of unknown source and/or misappropriation of resident property will be immediately reported to the administrator of the provider as required by state law. -10. Written grievance decisions will include: -a. the date the grievance was received, -b. a summary statement of the resident grievance, -c. steps taken to investigate the grievance, -d. a summary of the pertinent findings or conclusions regarding the resident's concern(s), -e. a statement as to whether the grievance was confirmed or not confirmed, -f. any corrective action taken or to be taken by the facility as a result of the grievance -g. the date the written decision was issued. -11. The facility will take appropriate corrective action in accordance with State law if the alleged violation of the residents' right is confirmed by the facility as a result of the grievance, and the date the written decision was issued. -12. The facility will maintain the results of all grievances for a period of no less than 3 years from the issuance of the grievance decision. -13. A grievance may also be filed with the State agency, Quality Improvement Organization, State Survey Agency, and the State Long-Term Care Ombudsman program or protection and advocacy system. Review of Resident #43's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/5/24, showed: -Severe cognitive impairment; -Incontinent of bowel and bladder; -Mobility: -Roll left and right-Substantial/maximal assistance; (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Sit to lying-Substantial/maximal assistance (Helper does more than half the effort); -Lying to sitting on side of the bed-Substantial/maximal assistance (Helper does more than half the effort); -Sit to stand-Substantial/maximal assistance (Helper does more than half the effort); -Chair/bed-to-bed transfer-Substantial/maximal assistance (Helper does more than half the effort); -Toilet transfer-Substantial/maximal assistance (Helper does more than half the effort); -Diagnoses included high blood pressure, end stage renal disease (ESRD) and dementia. Review of the resident's electronic Physician Order Sheet (ePOS), showed: -No orders related to the resident's transfer status. Review of the facility provided grievances for the resident, showed: -A grievance, dated 8/31/24, related to nursing care by the resident's family member. -Description: Stand up lift versus Hoyer lift (mechanical full body transfer). The resident is in severe pain and using the stand lift affects his/her knees. Would you please not allow the use of stand lift? Due to the resident's condition, the Hoyer lift is more suitable and less stress on the resident's armpit, waist, and his/her knees. -Summary/Findings: Therapy department will evaluate the resident to make sure he/she is appropriate for either stand up lift versus Hoyer lift. -Recommendations/Action Taken: Therapy will evaluate resident for correct device for transferring. -Date resolved: 8/31/24. Review of the facility provided Nursing Grievances, dated 9/3/24, showed: -9/3/24 Resident #43. Downgrade to Hoyer lift per Director of Therapy (DOT). Check right side Hoyer lift. In-service staff on 9/4/24. Review of the resident's medical record showed: - The resident's care plan, in use at the time of the resident's discharge, did not show how to transfer the resident. - The resident was discharged from the facility to the hospital on 9/11/24 and did not return to the facility. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/8/24 at 9:45 A.M., the DOT said with the resident's cognitive status and resistance to care, the Hoyer was not safe for the resident. The sit-to-stand was hard because of the resident's mobility. The resident had received therapy while a resident at the facility but was discharged from therapy around May. The resident was not getting therapy when the resident left the facility. The resident was not evaluated for the use of a Hoyer lift because therapy thought the resident would be too shaky for it, but the resident was too weak for the sit-to-stand. During an interview on 10/8/24 at 11:05 A.M., the DOT provided the resident's admission and discharge Occupational Therapy records, dated April and May 2024. He said that was the last time therapy evaluated the resident. He said therapy never put the resident in a Hoyer. As far as he knew, the facility did not reach back out to the resident's family member to say the evaluation was not done. He does not remember if he told Social Services the evaluation was not done. The resident's transfer status is 2-4 staff assistance with the gait belt. The order should be in the chart and care planned. There would have been an assessment note if therapy evaluated the resident. During an interview on 10/8/24 at 11:26 A.M., Social Services said the DOT told her the resident was not appropriate for the Hoyer lift or the sit-to stand. The Social Worker said therapy evaluated the resident. When informed, the DOT said the resident was never evaluated, the Social Worker said she was not aware of that. She thought the DOT evaluated the resident. The DOT told her the resident was not appropriate for either type of transfer, so she assumed he evaluated the resident. During an interview on 10/8/24 at 12:45 P.M., Certified Nursing Assistant (CNA) E said the resident was a two person transfer with a gait belt (prior to discharge). During an interview on 10/8/24 at 2:45 P.M., the Administrator said she expected the evaluation to be done if that is what therapy said they would do. MO00243151

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34477 Based on interview and record review, the facility failed to thoroughly and accurately assess, document, and notify the physician of a change in condition sustained by two of 14 sampled residents (Residents #44 and #36) and one closed record (Resident #306). Resident #44 had a diagnosis of congestive heart failure and history of fluid retention. The facility failed to monitor and report the resident's weight gain and respiratory changes. Resident #44 was transported to the hospital and administered intravenous Lasix (diuretic). Resident #306 experienced symptoms of confusion and inability to use a motorized wheelchair. The facility received orders for lab work on 6/6/24 and critical lab results were sent to the facility on [DATE]. Resident #306 continued to experience a change in condition that included inability to use utensils and increased confusion. Between 6/7 and 6/9/24, nursing staff failed to notify the physician of the critical labs and the resident's worsening status until 6/10/24. The resident was transported to the hospital with diagnoses of acute kidney failure and urinary tract infection. The facility also failed to order a urinalysis for Resident #36, who went to the hospital one week later with a diagnosis of kidney infection. The census was 53. Review of the facility's Change in Resident's Condition or Status policy, revised August 2008, showed: -The Director of Nursing (DON) or designee will notify the resident's Attending Physician or On-Call Physician when there has been: -An accident, incident, unusual occurrences, abuse situation, or allegation of abuse involving the resident (ex: choking episodes and etc.); -A discovery of any injury - with cause known or unknown; -A reaction to medication/medication error; -A significant change in the resident's physical/emotional/mental condition; -A need to alter the resident's medical treatment significantly; -Refusal of treatment or medications as clinically appropriate; -A need to transfer the resident to a hospital/treatment center; -A discharge without proper medical authority (Against Medical Advice); and/or -Instructions to notify the physician of changes in the resident's condition; -A significant change of condition is a decline or improvement in the resident's status that: -Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self limiting); (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-Impacts more than one area of the resident's health status; -Requires interdisciplinary review and/or revision to the care plan; -The final decision regarding what constitutes a significant change in status is based on the judgment of the clinical staff and the guidelines outlined in the Resident Assessment Instrument; -DON or designee will notify the resident/ legal representative when: -The resident is involved in any accident, incident or unusual occurrence with or without injury including injuries of an unknown source; -Abuse situations, or allegations of abuse; -There is a significant change in the resident's physical. mental. or psychosocial status; -There is a need to change the resident's room assignment; -A decision has been made to discharge the resident from the facility; -It is necessary to transfer the resident to a hospital/treatment center; -Notification will be made as soon as possible (within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status.). In medical emergencies notification should be made as soon as possible after occurrence of the event; -The DON or designee will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status; -If a significant change in the resident's physical or mental condition occurs, a comprehensive assessment of the resident's condition will be conducted as required by current Omnibus Budget Reconciliation Act (OBRA) regulations governing resident assessments and as outlined in the Minimum Data Set (MDS) 2.0 RAI Instruction Manual; -A representative of business office/ social service will verify the address and telephone number of the resident's family or legal representative on a quarterly basis. Any noted changes will be reported to the Director of Nursing Services to ensure that such information is changed in the resident's medical record; -A representative of the business office will notify the resident, his/her family, or legal representative when there is a change in resident's billing status. 1. Review of Resident #306's medical record, showed: -admitted on [DATE]; -Diagnoses of hypertension (HTN, high blood pressure), chronic kidney disease, constipation, gastroenteritis and colitis (a digestive disease that causes inflammation of the colon's mucosal lining). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/10/24, showed: -No cognitive impairment; -Diagnoses included hypertension, renal failure, depression, anemia, and asthma; -Always incontinent of bowel and bladder; -Independent with eating at admission; -Uses motorized wheelchair. Review of the resident's care plan, dated 2/2/24, showed: -Focus: Has an Activity of Daily Living (ADL) self-care performance deficit related to weakness and limited mobility. He/She is non-ambulatory and uses a motorized wheelchair for mobility; -Goal: The resident will improve current level of function in transfers; -Interventions: Monitor/document/report PRN (as needed) any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function. Review of the resident's progress notes, showed: -On 6/6/24 at 2:50 P.M., Resident exhibiting increased confusion and inability to bear weight. Resident displays difficulty navigating in his/her motorized wheelchair due to gross bilateral lower extremity (BLE), edema and weakness. Informed DON, Physical therapy (PT) assessed and provided regular wheelchair. Resident's transfer status changed to Hoyer lift (mechanical lift) at this time. Call placed to physician's office to report and request order for lab work. Call placed to power of attorney (POA), message left; -On 6/6/24 at 3:44 P.M., Call back from physician's office. Order obtained for complete blood count (CBC, determines general health status and screens for and monitors for a variety of disorders) and basic metabolic panel (BMP, measures several important aspects of your blood). Call placed to lab and informed of need for draw. Phlebotomist will be out on next business day. Requisition completed. Call placed to responsible party (RP), message left; -On 6/7/24 at 11:21 A.M., late entry: lab here for blood draw. Results pending. Review of the resident's vital signs, showed no documentation of the resident's temperature on 6/6 through 6/9/24. No documentation of the resident's respirations on 6/6 through 6/9/24. Review of the resident's critical lab results, showed: -Collection date: 6/7/24 at 10:40 A.M.; -Received date: 6/7/24 at 4:00 P.M.; (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-Glucose showed 48, critical low (reference range/cut off 82-115); -BUN showed 59, critical high (reference range/cut off 8-23); -Bicarbonate (CO2) showed 13, critical low (reference range/cut off 22-29); -Originally reported on 6/7/24 at 5:25 P.M. Review of the resident's progress notes, showed: -On 6/8/24 at 7:28 P.M., resident requires assists with feeding. He/She not able to use utensils. Resident has increased confusion, able to answer simple yes or no answers. RP informed of changes. Continue on antibiotic therapy for cellulitis (a bacterial infection that affects the deeper layers of the skin and the tissue underneath). Encourage fluids; -No documentation of acknowledgement of critical lab results or notification of change in condition to physician between 6/7 through 6/9/24; -No documentation of an assessment or monitoring the resident's change in condition on 6/9/24; -On 6/10/24 at 7:00 A.M., patient remains on close observation for antibiotic related to cellulitis. Zero complaints of pain or discomfort. Patient was resting in bed all night with eyes closed. Patient appeared to be asleep but easily awaken with call light in reach; -On 6/10/24 at 4:06 P.M., resident exhibits listlessness (a state of having little to no interest in anything, or a lack of energy), malaise (a general feeling of discomfort, uneasiness, or lack of well-being), and disorientation. Final lab results received. Many high and low values as well as critical results. Labs faxed and called to physician's office. Call back received from Physician L. Telephone orders received to send to emergency room for evaluation and treatment for abnormal labs. Call placed to daughter and informed. DON made aware. Call placed to local 911 for transport. Ambulance service had no available units; -On 6/10/24 at 5:02 P.M., Emergency Medical Service (EMS) in facility. Assumed care of resident. Report given. Exited facility in route to emergency room . Report called to nurse. Review of the resident's vital signs, showed: -On 6/10/24 at 4:44 P.M., the resident's temperature was 97.3 degrees Fahrenheit (F). -On 6/10/24 at 4:44 P.M., the resident's respirations were 20 breaths per minute. -No documentation of the resident's blood sugar on 6/6 through 6/10/24; -No documentation of the resident's oxygen saturation on 6/6/ through 6/10/24. Review of the resident's Physician Order Sheets (POS), showed an order, dated 6/10/24, to send to the hospital for evaluation and treatment for abnormal lab values. (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	08/19/2024

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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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/15/24 at 11:48 A.M., the Administrator said they were looking into the resident's labs from 6/6/24, to see when it was reported. They had notes during their clinical meeting about the resident's change in condition. They ordered the labs and they were the ones who sent the resident out as well. They noticed the change in condition. During an interview on 8/15/24 at 1:17 P.M., Licensed Practical Nurse (LPN) M said the results were faxed from the lab and he/she had access to look at the labs as well. The lab company would call the facility and fax any critical labs. If there was a critical lab, he/she would call the physician immediately and give the results. Physician L wanted the resident sent out. LPN M received a verbal order to send the resident out and he/she faxed the lab results. During an interview on 8/15/24 at 1:26 P.M., Receptionist O from the lab company said there was a phone call to the facility attempted on 6/7/24 between 5:30 P.M. and 5:45 P.M. with no answer. The facility has three fax numbers on file, and the lab faxed the lab results to all three fax numbers between 5:26 P.M. and 5:27 P.M. The lab results were uploaded to the online portal as soon as the results were completed. It was instant. There was also an email on file and the lab results were also emailed. He/She read the email address that belonged to RN B. The only confirmation he/she was able to see was the system showed a status of completed. During an interview on 8/16/24 at 8:40 A.M., the DON said if there were critical labs, the lab would call the facility. Critical labs were also faxed and emailed. When she spoke to the lab company, they said they would call and send results to the three fax numbers they had. Nursing was expected to call the physician and fax the lab results to the physician. If they did not get the physician right away, she expected nursing to call back and relay a message. The DON did not have any knowledge of what happened with the lab results for the resident. She expected nursing to contact the physician if a resident had a change in condition. She expected nursing to contact the physician if the resident had a change in condition during the weekend. The resident's oxygen saturation should have been checked and blood sugar as well, regardless if diabetic or not. The DON said the resident's glucose on the lab result would be considered low. The resident's lab results should have been addressed immediately. If staff could not reach the physician, they could call the family and send the resident out to the emergency room for evaluation. During an interview on 8/16/24 at 10:14 A.M., the Social Worker for Physician L said on 6/6/24, the Nurse Practitioner ordered a BMP/comprehensive metabolic panel (CMP, measurement of blood sugar, electrolyte, fluid balance, kidney and liver function). The nurse reported the resident had increased confusion, safety concerns using a manual wheelchair and would be transferred in a Hoyer lift. On 6/10/24, it was reported to the physician there were critical labs. They received labs at 3:15 P.M. Physician L ordered to send the resident to hospital due to critical labs. Staff were expected to call the physician for critical labs. There was no documentation the facility contacted Physician L between 6/7 and 6/9/24, but he/she could not say the facility did not call or if they tried to contact the physician. But they could call the exchange on the weekends. Sometimes there was not a quick turn around with labs, they were seeing a trend. Labs results were not coming in from the lab like they used to. The facility should follow their policy in regards to monitoring and assessment for a change in condition, but the facility had a plan in place and notified the office. They had a safety plan for the resident and the labs were reported to them. If staff continued to have concerns regarding the resident's symptoms, staff could call the exchange on the weekend. (continued on next page)

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	265735	A. Building B. Wing	08/19/2024

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/16/24 at 9:41 A.M., medical assistant for Physician K said the resident had diagnoses of colitis, chronic obstructive pulmonary disease (COPD, a chronic inflammatory lung disease that causes obstructed airflow from the lung), and a skin ulcer on the right heel. The resident was last seen by Physician K on 5/23/24. There was documentation positive for leg swelling, but no chest pain or palpitations. There was no documentation the facility contacted the physician between 6/7 through 6/10/24. The medical assistant read the documentation from the emergency roiagnom on [DATE]. The resident was admitted for acute renal failure and urinary tract infection (UTI). It was documented the resident was discharged back to the facility and eventually went home for hospice care. During an interview on 8/18/24 at 9:36 A.M., LPN T vaguely remembered the weekend of 6/7 through 6/9/24. He/She remembered the resident started to decline. He/She could not recall anything about 6/7/24, but in general, the resident's condition declined more. He/She had more confusion, and already had weakness on one side. He/She did get to a point he/she could not hold utensils. LPN T did not recall receiving any critical labs that weekend or the resident's labs in general. LPN T was not aware of any labs. The resident was definitely slowly declining and had wounds on his/her lower leg. At baseline, the resident was alert, he/she was up, and used a mobilized wheelchair. His/Her left side was weaker than the other side. He/She went to the hospital and was not really the same when he/she came back. He/She had a lot of incontinent episodes of stool and constant bowel movement. LPN T spoke with the resident's POA about the decline. The POA noticed a decline as well and wanted another opinion from Physician K. He/She had started to decline at that point. They had to feed the resident when he/she declined. When he/she had loose stools, the resident stayed in bed. They put the resident in the regular wheelchair. LPN T did not remember notifying anyone at that point during that weekend. They continued to monitor his/her blood pressure and temperature. During an interview on 8/18/24 at 4:32 P.M., LPN U said he/she remembered the resident. In general, he/she remembered working the weekend of 6/7 through 6/9/24. The resident was in the hospital at one point prior to that weekend. The resident was not herself when he/she came back. LPN U remembered that the resident was unsafe in the mobile chair, so they suggested a Hoyer for his/her safety and staff safety. LPN U remembered the resident had labs done, but it was toward the end, right before the resident was sent to the hospital. He/She remembered they were monitoring the resident closely, as they would with a change in condition. They were doing full assessments, mental and physical, and vitals. The resident was alert and oriented and could have a conversation. The nurse did not remember what happened in specifics of assessments on the weekend of 6/7, but they were monitoring the resident every hour. He/She did not have his/her light on, but the rounds were done hourly. He/She could not recall if anyone was notified. If he/she called, it would have been documented. (continued on next page)

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	265735	A. Building B. Wing	08/19/2024

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/16/24 at 12:29 P.M., the Administrator said she expected staff to contact the physician if the resident had a change in condition on 6/8 that showed he/she could not use utensils or required assistance with feeding. Staff should have called the exchange. The change in condition policy was referring to the condition, but a baseline was needed. Staff should get vitals and any assessments that were appropriate for the change that resident was having. Staff should always have baseline vitals so they can compare previous to current. Blood sugar should be checked if they were on dialysis or diabetic, but she would have to see new protocols on that. Oxygen saturation, blood pressure, respirations, and temperature should be obtained. She expected nursing to notify the physician timely for the labs. The Administrator said the resident's critical labs should have been addressed immediately. The only thing that was mentioned to her was the resident had frequent stools. They were discussing the resident having a private room, but it was related to frequent stools. It was the last month before he/she went out. She expected staff to routinely check labs because the resident could become dehydrated due to the loose stools. She expected the resident to be hydrated and receive fluids. They had a plan in place for the frequent stools, as it was discussed in the clinical meeting. The Administrator was not aware of the resident being sent to the hospital prior to 6/10/24. From 6/7 through 6/11/24, the Administrator did not receive any information on the resident. 2. Review of Resident #44's admission MDS dated [DATE], showed: -Severe cognitive impairment; -Required set-up for eating and oral hygiene; -Required supervision for showering and personal hygiene; -Mobility: independent; -Diagnoses included heart failure, high blood pressure, dementia and COPD. Review of the resident's care plan, last revised on 6/5/24 and in use during the survey, showed: -Focus: Resident has congestive heart failure (CHF, a chronic condition that occurs when the heart can't pump blood efficiently enough to meet the body's needs and can cause fluid build up in the body's organs); -Goal: The resident will have clear lung sounds, hear rate and rhythm within normal limits; -Interventions included: -Monitor lab work: Potassium (K+, measures amount of potassium in the blood), Sodium (NA, measures amount of sodium in the blood), blood urea nitrogen (BUN, measures amount of urea nitrogen in the blood), creatinine (measures how well the kidneys are filtering waste form the blood); -Monitor/document PRN any signs/symptoms of CHF: weight gain unrelated to intake, shortness of breath (SOB) upon exertion, dependent edema (swelling that occurs in areas of the body affected by gravity, happens when extra fluid gets trapped in the body's tissues) of legs and feet, perioribital edema (swelling around the eyes due to fluid buildup and inflammation), weakness and/or fatigue. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's Physician Orders, showed: -An order, dated 5/3/24, Albuterol Sulfate Inhalation Nebulization Solution (treats sudden episodes of difficulty breathing) (2.5 milligrams (mg)/3 milliliter (mL)), 3 mL inhale orally via nebulizer PRN for SOB/wheezing. Administer one vial four times a day PRN for wheezing/SOB; -An order, dated 5/3/24, apply oxygen (O2) per nasal canula (a device that delivers extra oxygen through a tube into the nose) PRN and check O2 (saturation (sat, amount of oxygen in the blood) every shift PRN for SOB. Notify physician if below 90%; -The order did not specify the flow rate of oxygen; -An order, dated 6/14/24, Advair Diskus Inhalation Aerosol Powder Breath Activated (medication used to prevent SOB and wheezing) 250-50 microgram (mcg)/act, two puff inhale orally, every 12 hours related to other emphysema (COPD); -An order, dated 6/13/24, Albuterol-Budesonide Inhalation Aerosol (used as needed to treat and help prevent asthma (inflammation and narrowing of the small airways in the lungs) symptoms, 90-80 mcg/act, two inhalations inhale orally every four hours as needed for shortness of breath; Dyspnea (feeling like you cannot get enough air, air hunger). Review of the resident's weights, showed: -5/3/24, 127.6 pounds (lbs); -5/16/24, 130.2 lbs; -5/21/24, 128.8 lbs; -5/31/24, 128.5 lbs. Review of the resident's progress notes, showed: -A Nutrition/Dietary note dated 5/31/24 at 11:59 A.M., New Admit Note; Resident able to make needs known. Resident on a low-calorie sweeteners (LCS, sugar substitutes used), no added salt (NAS) diet. Regular texture. Thin consistency. Resident is particular about diet and practices a vegetarian lifestyle. Resident has no concerns of chewing or swallowing. Resident has a moderate appetite--consumes 75-100% of meals. Resident is independent with meals. 5/31: 128.5 lbs. Will continue to follow and intervene as needed. Review of the resident's weights, showed: -6/12/24, 134.8 lbs. Review of the resident's progress notes, showed: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-A Weight Change note, dated 6/21/24 at 4:38 P.M., Weight Change Warning: Value: 134.8 lbs. Vital Date: 6/12/24 3:38 P.M., +5.0% change. Registered Dietician (RD) recommends notifying the physician of weight gains with history of fluid retention. Follow as needed; -No documentation staff contacted the resident's physician regarding the increase in weight; -A Nurses note, dated 6/26/24 at 2:21 A.M., Weekly weight obtained, 138.8 lbs standing; -No documentation staff contacted the resident's physician regarding the increase in weight. Review of the resident's weights, showed: -6/26/24, 138.8 lbs; -7/3/24, 138.8 lbs. Review of the resident's progress notes, showed: -A Weight Change note, dated 7/10/24 at 11:54 A.M., Weight Warning: Value: 138.8. Triggered for previous weight gain trends, remains stable with no new recommendations, follow as needed; -No documentation staff contacted the resident's physician regarding the increase in weight; -An Order note, dated 7/22/24 at 2:26 P.M., Nurse Practitioner (NP) in to see patient. New orders received for labs: CMP, CBC, thyroid stimulating hormone (TSH, indicates how the thyroid gland is functioning), hemoglobin A1C (HgBA1c, measures the average amount of blood sugar), lipid panel (measures for cardiovascular disease), Vitamin D and B12; -An Order note, dated 7/22/24 at 2:28 P.M., Lab tech in to draw labs today; -A Nurses note, dated 7/24/24 at 11:38 A.M., Labs faxed to resident's physician's office with the following abnormals noted: mean corpuscular hemoglobin concentration 31.9 low (MCHC, blood test that measures average concentration of hemoglobin red blood cells. Normal range is 32-36), HgBA1c 6.0 high (normal range is below 5.7%), Creatinine 1.35 high (normal range is 0.6-1.1) and eGFR 39 low (a test that measures how well the kidneys filter waste and toxins in the blood, normal range is 90 or higher). Review of the resident's vital signs for August 2024, showed: -On 8/6/24, respiration 18 breaths per minute; -On 8/6/24, O2 saturation of 96% at room air. Review of the resident's weights, showed: -8/7/24, 143.8 lbs; -The resident had an 11.9% weight gain in three months. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Observation and interview on 8/12/24 at 11:50 A.M., showed the resident sat on his/her rollator in the hallway. He/She said he/she was resting. The resident said he/she just finished a breathing treatment. A nebulizer mask (a device that allows a person to inhale liquid medicine in the form of a mist that goes directly into their lungs) was observed on the resident's bed. The resident said he/she received treatments when out of breath. An O2 concentrator (a medical device that takes in air from the room and filters out nitrogen to provide higher concentrations of oxygen for breathing) sat next to the resident's bed. The resident said he/she used it at night and whenever he/she was out of breath. He/She said it should be set on two liters (L, flow rate). Observation showed the concentrator was set at 2 L. Observation and interview on 8/13/24 at 8:55 A.M., showed the resident lay in bed on his/her side and wore a nebulizer mask. He/She said he/she felt weak today. The nurse was aware and that's why he/she was doing a breathing treatment. Observation on 8/13/24 at 2:08 P.M., showed the resident lay in bed on his/her side. He/She wore the nasal canula to receive oxygen. The concentrator was set at 2 L. Review of the resident's progress notes, dated 8/13/24 at 2:31 P.M., showed the resident was complaining of weakness and SOB when walking. Vital signs (VS) are 127/82 (blood pressure, normal range is 90/60 - 120/80), 78 (pulse, normal ranges is 60-100 beats per minute), 20 (breathing, normal range is 12-18 breaths per minute), 98.6% (oxygen saturation, normal range is 95% -100% while resting) on room air, lung sounds. Medical doctor (MD) made aware and verbal order given for chest x-ray. X-ray, vendor called and scheduled. Observation on 8/14/24 at 9:18 A.M., showed the resident lay in bed on his/her side. The resident's nasal canula was next to him/her on the bed. Review of the resident's August 2024 Medication Administration Record (MAR), showed staff did not document administering the PRN nebulizer treatments, PRN oxygen or PRN O2 saturation. Review of the resident's vital signs for August 2024, showed: -No other documentation regarding the resident's respiratory status. Review of the resident's progress notes, showed: -On 8/14/24 at 2:32 P.M., a Weight Change note, Weight Warning: Value 143.8 lbs. +7.5% change, +10.0% change. Resident reviewed by RD for weight gain trends., recommend contacting the physician to notify of gains with history fluid retention and cardiac concerns; -On 8/14/24 at 5:39 P.M., a Nurses note, Skilled received orders to send patient to emergency room for evaluation and treatment related to SOB, increased activity intolerance and decreased endurance, productive cough green and brown sputum (phlegm), noted and reported signs and symptoms; -On 8/15/24 at 6:30 A.M., Nurses note, Patient was admitted to hospital with diagnosis of CHF exacerbation. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/15/24 at 9:04 A.M. and 1:05 P.M., Registered Nurse (RN) B said the resident went out to the hospital at 6:06 P.M. on 6/14/24. There was a chest x-ray ordered, but the results hadn't been received. Yesterday the resident had increased SOB when walking and green/brown sputum. The MD saw the resident the day before. The resident did not have a lot of edema, it was more SOB. The resident's condition was getting progressively worse. If a resident felt lethargic or had SOB, RN B would check the resident's O2 saturation. He/She was not sure what the facility's standard was for checking O2, but he/she would check it to make sure it was within range. RN B was not sure how dietician recommendations were processed or who put them in place. RN B saw nutritional notes in the resident's record. If he/she received an order for labs, he/she would make a progress note and put the order in and then fax it to the lab. Once the lab results were received, if they were critical, the doctor should be called. If they were not critical, then they would be faxed. There should be a follow up note on the lab results to say if the doctor gave new orders or not. During an interview on 8/15/24 at 9:51 A.M., the RD said she had concerns about the resident's elevated weight caused by fluid retention. She provided her feedback within 48 hours of reviewing a resident. She did not receive any response from facility staff regarding her June recommendation to notify the doctor of the resident's significant weight increase. RD recommendations were sent to the Administrator and DON, who then contact the physician. Usually nursing would follow through if there's an order. During an interview with the Administrator and DON on 8/16/24 at 9:37 A.M., the Administrator said the nurse should have contacted the doctor regarding the resident's increased weight especially since he/she had CHF. If the resident became more labored with breathing, staff should have monitored him/her more frequently. If the resident used continuous O2, it should have been documented somewhere. Staff should have documented their monitoring and observations of the resident. The resident's vitals should have been documented. There could have been additional monitoring and interventions with the resident's change in condition. 3. Review of Resident #36's quarterly MDS, dated [DATE], showed: -Severe cognitive impairment; -Moderate to total staff assistance needed for hygiene, toileting, mobility and transfers; -Always incontinent of bowel and bladder; -Had a urinary tract infection (UTI) in the last 30 days; -Diagnoses included diabetes, stroke, paralysis, heart failure and Alzheimer's disease. Review of the care plan, in use during the survey, showed: -Focus: Bladder incontinence; -Goal: the resident will remain free of UTI's; (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-Interventions: encourage fluid throughout the day, keep skin clean and dry, labs/diagnostics as ordered and report to the physician, monitor and document for a UTI such as pain, burning, blood tinged urine, foul smelling urine, fever and change in mental status. Review of the progress notes, dated 7/14/24 at 2: 50 P.M., showed the resident complained of burning upon urination. Upon assessment, hematuria (blood in the urine) noted. Physician notified and new order given to obtain a urinalysis (UA) and culture. Staff may straight catheterize (a procedure that involves inserting a hollow, soft-tipped urinary catheter into the urethra and into the bladder to drain urine) if needed. Review of the POS, showed no documented orders for the urinalysis and culture. Review of the progress notes from 7/14/24 through 7/22/24, showed no documentation regarding the ordered UA testing or resident urinary status. Review of the progress notes, showed: -On 7/23/24 at 10:12 A.M., the resident placed into the bed to obtain the UA sample. Staff attempted twice. No UA sample obtained; -On 7/23/24 at 12:35 P.M., NP notified the resident had a mental status change. Staff attempted twice to obtain UA sample with no results. New order received to send to the emergency room (ER) for evaluation and treatment; -On 7/23/24 at 2:47 P.M., emergency services notified, the resident had an acute mental status (AMS)change and low blood pressure. Current vital signs: blood pressure 130/47 (normal 120/80), pulse 82 (normal 60-80), respirations 16 (normal 12-18) and temperature 97.4 degrees (normal 97.1-99.1 degrees); Review of the hospital admission history and physical, dated 7/23/24 at 11:45 P.M., showed: -History of present illness: the patient is alert to self and place. He/She was sent to the ER for AMS and hematuria. The obtained UA sample is red and cloudy. Urine culture is pending. The patient administered intravenous (IV) ceftriaxone (antibiotic); -Assessment and plan: acute encephalopathy (rapid brain dysfunction and mental status change), acute cystitis (bladder infection) with hematuria; -Acute encephalopathy due to UTI: Administer ordered cefepime (antibiotic). Review of the

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35394 37672 Based on observation, interview and record review, the facility failed to ensure one resident who readmitted to the facility with an identified Stage II pressure wound (a partial thickness loss of the skin epidermis and dermis that appears as an open wound or blister) to the coccyx (tailbone) did not develop worsening or additional skin wounds. The facility failed to conduct re-admission wound measurements, transcribe hospice wound care orders, and notify the physician of the wound. As a result, the wound the resident had on admission got larger and appeared to have slough (moist dead tissue) that developed which is consistent with a Stage III pressure injury (full tissue loss) (Resident #9). The sample size was 14. The census was 53. Review of the state operations manual, showed the following definitions for staging pressure ulcers: -Stage 2 Pressure Ulcer: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present; -Stage 3 Pressure Ulcer: Full-thickness skin loss Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss. Review of the facility's undated pressure/skin breakdown protocol, showed: -Policy specifications: -Document the significant risk factors for developing pressure sores, such as immobility, weight loss and history of pressure wounds; -The nurse shall assess and document/report the following: -Full assessment of the skin condition including but not limited to the location, stage, partial (extends partially into the muscle) or full (extends through all muscle tissue) thickness, length, width, depth and presence of exudate (drainage) or necrotic (black, dead) tissue; -Pain assessment; -The resident mobility status; -Current treatments, including supportive devices; -All active diagnoses; (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	08/19/2024

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Examine the skin of any new admission for any alterations of skin integrity; -The physician will assist staff define the type of ulceration; -Identify the factors contributing or predisposing residents to skin breakdown, such as medical comorbidities and macerated (breakdown caused by frequent wetness) or friable (thin, delicate) skin; -Document any signs/symptoms of infection, skin condition assessment, the impact of other diagnoses on wound healing; -The physician will give orders related to wound treatments, including pressure redistribution surfaces, wound cleansing and debridement (surgical removal of dead tissues) approaches, dressing and application of topical agents; -The physician will help identify medical interventions related to the wound management; -The physician will help staff characterize the likelihood of wound healing; -As needed, the physician will help identify medical and ethical issues influencing wound healing. Review of Resident #9's quarterly Minimum Data Set (MDS) a federally mandated assessment instrument completed by facility staff, dated 5/4/24, showed: -Moderate cognitive impairment; -Does not resist care; -Physical impairment one side upper extremity; -Staff provided substantial to maximum assistance: toileting, bathing, dressing, repositioning, and bed mobility; -Diagnoses included: heart failure, diabetes, stroke, paralysis, depression and malnutrition; -At risk to develop pressure injury; -Had moisture associate skin damage (MASD, inflammation or skin erosion caused by prolonged exposure to moisture); -No pressure injury; -Used a pressure reducing device on the bed; -Application of ointments other than to feet. Review of the resident's care plan, in use during the survey, showed: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Focus: potential for impaired skin integrity and pressure ulcer development related to bowel and bladder incontinence, and requiring assistance for daily care; -Goal: The resident will have intact skin, and be free of redness; -Interventions: Staff administer treatments as ordered, assist with repositioning, follow facility protocol for prevention of skin breakdown, monitor skin with routine care and immediately notify the nurse of changes, and weekly skin assessments. Review of the facility wound report, dated 6/7/24 through 8/7/24, showed the resident not listed. Review of the progress notes, showed on 8/9/24 at 9:49 A.M., a nurse note: the resident readmitted to the facility from. He/She had a Stage II to the sacrum (tailbone) and a dressing in place. He/She is awaiting hospice evaluation. Review of the resident's re-admission Braden scale (assessment tool commonly used in health care to assess and document a client's risk for developing pressure ulcer) risk assessment, dated 8/9/24, showed a score of 9 or very high risk to develop pressure injury Review of the resident's progress notes, showed on 8/9/24 at 10:40 A.M., a nurse documented the resident was assessed and admitted into hospice services. Currently awaiting orders. Review of the resident's hospice admission assessment, dated 8/9/24, showed: -Wound protocol: -Wound #1: Pressure injury, lower back-tailbone; -Skin prep (protective barrier wipe); -Cover with foam border dressing; -Change every day and as needed (PRN). Review of the resident's electronic Physician Order Sheet (ePOS), reviewed on 8/12/24 at 4:17 P.M., showed no orders for wound care or wound treatments. During observation and interview on 8/14/24 at 7:42 A.M., Certified Nurse Aide (CNA) J entered the resident's room and assisted the resident to stand at the bathroom grab bars and removed the resident's pants and brief. CNA J said the resident had an open wound on the left buttock and added the resident recently returned from the hospital. CNA J said the wound had a treatment yesterday morning, and the dressing fell off yesterday afternoon, he/she told the nurse yesterday. He/She started the shift today at 6:30 A.M. and he/she did not see a treatment in place at morning care. Observation of the resident's left upper buttock and the left mid-buttock showed two open, uncovered wounds. The wounds appeared red and approximately nickel sized. CNA J cleaned and dried the wounds. CNA J applied skin barrier ointment to the wounds and buttock area. CNA J reapplied the brief, and pulled up the resident's pants. CNA J assisted the resident into the main dining room and did not notify the nurse of the open areas. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's medical record, reviewed on 8/14/24 at 11:53 A.M., showed no documentation of wound care orders, wound assessment, or wound measurements. During an observation and interview on 8/14/24 at 1:09 P.M., Licensed Practical Nurse (LPN) C said he/she readmitted the resident to the facility on [DATE]. The resident was admitted to the facility with a small open area close to his/her coccyx area. The resident was admitted to hospice services on 8/9/24. He/She was the nurse on duty and he/she spoke to the hospice nurse after the admission. He/She last worked at the facility on 8/9/24. LPN C said he/she was not notified of any additional wounds by any nurse or aide and added the resident did not have current wound care orders in the medical records. LPN C entered the resident's room [ROOM NUMBER]/14/24 and removed the sheet and exposed the resident's buttocks. LPN C said there were multiple open wounds to the resident's left inner upper and midline buttock. The two wound measurements noted: -Left upper, inner buttock: Stage II pressure ulcer (PU): 2.0 centimeter (cm) x 0.8 cm x 0 cm. Skin gray and slough noted, surrounding tissue red and inflamed; -Left midline buttock: Stage II PU: Measured 0.5 cm x 0.4 cm x 0.0 cm. Surrounding tissue red, inflamed. When LPN C cleaned the area, the resident said Ouch, stop, it hurts. -In addition, there were approximately 6 additional open wounds scattered across the left buttocks, LPN C said the wounds appeared from shearing. LPN C said the resident had more wounds since he/she returned to the facility. The wound near the tailbone, that he/she had assessed upon re-admission, had gotten larger and appeared to have slough. LPN C said he/she did not notify the physician of the wound near the tailbone when the resident readmitted to the facility. The resident was admitted to hospice services, and LPN C assumed the hospice provider would obtain wound care orders. The hospice provider did not notify LPN C of any wound care orders after admission into hospice. On 8/14/24 at 2:21 P.M., LPN C reviewed the hospice plan of care binder. He/She noted the wound care orders and said the wound care orders did not get entered into the medical records. The aides should have reported the changes in the skin since the resident's re-admission. If aides notice a change in the skin or no treatments, they should notify the nurse immediately so an assessment and treatment can be applied. The resident should have an air mattress, the resident currently had a standard mattress. LPN C would notify the hospice provider of the skin condition and obtain orders. Review of the resident's medical record, reviewed on 8/15/24 at 6:50 A.M., showed no wound measurements from 8/14/24 and no physician or hospice notifications. Observation on 8/15/24 at 7:48 A.M., showed the resident asleep in bed, on his/her back on a standard mattress, with a brief noted in place. During an interview on 8/15/24 at 7:49 A.M., LPN C said he/she had forgotten to document the wound assessment from 8/14/24. He/She called the hospice provider on 8/14/23 and requested wound care orders. The hospice provider had not responded before he/she left work after 7:00 P.M., on 8/14/24. LPN C did not call the physician to obtain wound care orders and continued to wait for the hospice provider to respond with orders as of the time of the interview. LPN C said hospice should obtain orders for the wound care. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/15/24 at 7:55 A.M., the Director of Nursing (DON) said she had been employed at the facility since July 2024. the facility did not have a wound care nurse, and the DON was recently notified by the Administrator that she was responsible for tracking wounds. She expected aides to immediately notify the nurse of any skin changes. The nurse should immediately assess the resident's skin, obtain measurements, and notify the physician for orders. The nurses should notify the DON of any wounds and she would add the resident to the wound report. The facility wound report is two weeks behind, and she used the wound reports for wound identification. The wound report is based off staff reporting skin issues to her. If a resident is admitted with a wound, the admitting nurse should measure and document the wound. The physician should be notified and orders given. If the resident received hospice services, the same procedure should apply. Wounds need an initial measurement at the time of discovery, and then measured weekly after to monitor changes. The resident should get a weekly skin assessment by the charge nurses and this should be documented in the medical record. She was not notified of the resident's original wound on 8/9/24. LPN C notified her of the skin assessment from 8/14/24 on the morning of 8/15/24. LPN C should have documented measurements, started a wound event in the medical record, and contacted the physician. Nurses should not rely on hospice to obtain orders, that is the responsibility of the facility. The resident should have had wound care orders since the time of re-admission since a wound was noted at that time. It is the nurse's responsibility to ensure all hospice orders are documented in the medical record. During an interview on 8/15/24 at 1:35 P.M., the hospice director said the resident admitted on hospice services on 8/9/24. The admitting Registered Nurse (RN) documented a wound to the upper left buttock and documented wound care orders onto the start of care. Wound orders were obtained and verbally given to the facility charge nurse, LPN C. LPN C called the hospice provider on 8/15/24 and requested additional wound care orders and notified the hospice provider of additional wounds. The hospice director instructed LPN C to begin the treatments and the orders would be faxed over once the physician signed them. She expected facility staff to implement hospice orders when given, orders should be started when given to prevent a delay in care and treatment. The hospice nurses provide orders both verbally and written to the facility staff. Hospice staff also write orders in the hospice binder for additional information. During an interview on 8/16/24 at 8:45 A.M., the Administrator said all wounds should be measured, physician orders obtained, wound measurements and the type documented. If the resident received hospice care, the hospice nurse should give an oral report to the facility nurse. Hospice orders should be immediately transcribed into the medical record. If aides notice a change in skin condition, they should report it to the charge nurse or nurse supervisor immediately. MO00239868 50366

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35394 Based on interview and record review, the facility failed to ensure critical lab results were received and reported to the physician timely. The facility also failed to obtain a urine sample in a timely manner and did not document a reason for the delay in obtaining the sample for one resident (Resident #306). The sample was 14. The census was 53. Review of the facility's undated Lab, Diagnostic Test Results and Change in Resident's Condition policy, showed: -A licensed nurse will review all diagnostic tests results: -If a critical lab result is verbally reported by the lab provider to the nurse, the nurse will record and read back the report result to verify the information; -If the staff member who first receives or reviews lab and diagnostic test results is unable to follow the remainder of this procedure (i.e. reporting and documenting the results and their implications), another nurse in the facility should follow and coordinate procedural compliance; -The person who is to communicate results to a physician will review, compile the information and be prepared to discuss the following: -The individual's current condition and any recent changes in status, including vital signs and mental status; -Major diagnoses, allergies, pertinent current medications, other recent pertinent lab work, actions already taken to address the results and treat the resident, and pertinent aspects of advance directives (i.e. limitations on testing and treatment); -Why the rests were obtained; -How the test results might relate to the individual's current status, treatments, or medications; -Any concerns or issues the physician will be expected to address upon receiving the results; -The attending physician is responsible for responding in a timely manner to nurses regarding prompt notification calls or emergencies. The attending physician is also responsible for communicating the results of assessments and medical plans to a licensed nurse when appropriate; -Nurses should promptly notify the physician of any significant abnormal laboratory results. In such situations, direct communication with the physician is required and may not be faxed. Prompt calls must be made after office hours or when physician offices are closed. The following symptoms, signs and laboratory values should prompt the nurse to notify the physician as soon as possible: -Any laboratory result, normal or abnormal which the physician requested on a stat (immediately) or same day basis; (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-All panic or critical values; -Any of the following abnormal reports: -Glucose (sugar) < (less than) 60 or > (greater than) 200 in a diabetic or oral hypoglycemic or insulin-dependent or <60 in anyone (diabetic or non-diabetic), unless otherwise directed by the physician; -Blood Urea Nitrogen (BUN, measures how much urea nitrogen is in the blood) >40 without history of chronic evaluation or altered mental status; -Positive urine culture > 100,000 colonies/milliliter (ml) of a pathogen (only if 1). Resident has symptoms and is not on treatment; or 2). The pathogen is not sensitive to the antibiotic which has been prescribed); -Hemoglobin (amount of protein in red blood cells) <9, if not pre-existing and without treatment; -White Blood Count (WBC, blood test that measures the number of white blood cells in the blood) > 12, if not pre-existing; -Potassium (mineral that the body needs to work properly) <3 or >5.6; -Calcium (mineral) > 11; -Calcium > 12 (resident being treated with dialysis); -Abnormal reports when there are signs and symptoms of related illness assessed or outside of physician-ordered parameters, such as Hemoglobin, Hematocrit (measures the percentage of red blood cells), WBC, electrolytes (minerals in the blood and other body fluids that carry an electric charge), Dilantin (anti-epileptic) levels, prothrombin time (average time range for blood to clot), International Normalized Ratio (INR, blood test that measures how long it takes for blood to clot), etc.; -If a response from an attending physician concerning abnormal lab results is not obtained, the designated alternate physician should be called. If a response is still not received, the Director of Nursing/Designee should be notified for further instructions. In situations requiring immediate action (life threatening), 911 should be called first and physician notification second; -Normal test results may be faxed to the physician; -A physician should be notified of the following observations made in the course of routine nursing procedures that might require action: -Poorly controlled blood pressure in a resident on antihypertensive therapy; -Changes in urine or blood sugar values in diabetics (i.e. high blood glucose monitoring (BGM) values in a resident who is normally well controlled); -Poorly controlled blood sugars while on daily injections or sliding scale coverage; (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The following documentation should be entered into the resident's clinical record: -Any calls to and from the physician indicating information conveyed or received; -All orders taken from the physician or his designee (i.e. physician extender); -Ongoing conversations with the physician regarding response to notification(s) of changes in condition and/or laboratory/diagnostic test results. Review of Resident #306's medical record, showed: -admitted on [DATE]; -Diagnoses of hypertension (HTN, high blood pressure), chronic kidney disease, constipation, and gastroenteritis and colitis (a digestive disease that causes inflammation of the colon's mucosal lining). Review of the resident's progress notes, showed: -On 5/1/24 at 12:44 P.M., psychiatric Nurse Practitioner (NP) here in facility. New order Duloxetine (anti-depressant) 20 milligram (mg) daily. Responsible party (RP) made aware. RP stated resident was complaining of burning when urinating. This writer stated he/she would talk to resident and obtain urinalysis (UA, urine test) with culture sensitivity (CS); -On 5/3/24 at 12:04 A.M., spoke to resident's daughter about hospital recommendation for hospice. Resident may have a form of colon/rectal cancer. Refused colostomy (a surgical procedure that creates an opening in the large intestine (colon) through the abdominal wall) per hospital recommendation while inpatient. Per daughter they will follow up with previous primary due to relationship history in hopes resident will complete needed test for status confirmation. Will continue to monitor accordingly. In bed at this time. Does continue to have liquid stool frequency. Barrier cream applied after each incontinent episode; -On 5/7/24 at 9:03 P.M., attempted to obtain urine sample, no urine collected at this time; -On 5/8/24 at 3:29 A.M., obtain UA with CS every shift for three days. Strait cath (hollow, flexible tube used to urine from the bladder) attempted and was unsuccessful; -On 5/8/24 at 2:13 P.M., obtain UA with CS every shift for three days; -On 5/10/24 at 4:47 P.M., obtain UA with CS every shift for 3 days. No urine obtained; -On 5/22/24 at 12:48 A.M., attempted to retrieve urine sample via strait cath using 16 French (FR). Patient tolerated well, urine return successful. Urine sample labeled and placed in soiled utility fridge with lab requisition; -On 5/22/24 at 1:02 A.M., noted patient to have white genital discharge, patient denies any pain or discomfort. Call placed to Physician L for possible yeast infection. Also sent over a fax requesting to swab for yeast infection or possibly treatment. Will also pass on in report; (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 5/22/24 at 11:30 A.M., resident continues to have loose/watery stools without relief from as needed (PRN) Loperamide (used to control and relieve the symptoms of acute diarrhea). Previous shift nurse also reports thin, milky white genital discharge. Call placed to physician's office to report. Call back from NP. New orders received for Cholestyramine (used to lower high cholesterol levels in the blood) 4 gram packet by mouth, three times a day, before meals (ac), Lomotil (treats diarrhea) 2.5-0.025 mg, 2 tabs by mouth every six hours PRN, Diflucan (used to treat and prevent fungal infections) 150 mg tablet x 1 dose, Consult to Gastroenterologist (GI) for chronic diarrhea. Noted. Pharmacy faxed and called. Call placed to Power of Attorney (POA) and informed of new orders. Acknowledged and has no questions or concerns at this time. Shift supervisor informed of new orders; -On 5/22/24 at 1:44 P.M., urine specimen picked up by Lab. Results pending. POA informed. Shift supervisor made aware; -No documentation regarding the delay of obtaining the urine sample from 5/2 through 5/7/24 and no documentation the physician was notified that staff were unable to obtain urine sample timely. Review of the resident's urine culture lab results, showed: -Collection date: 5/22/24 at 12:30 P.M.; -Received date: 5/23/24 at 12:00 P.M.; -Result one: Escherichia coli (E. coli, bacteria); -Greater than 100,000 colony forming units per milliliter (mL); -Urine culture final report: Abnormal; -Originally reported on 5/27/24 at 12:05 P.M., -A stamped date, showed received on 5/29/24. Review of the resident's progress notes, dated 5/30/24 at 6:22 A.M., showed started Cipro (antibiotic) 250 mg last evening for a urinary tract infection (UTI). No signs or symptoms of any adverse reactions noted. Fluids encouraged. During an interview on 8/16/24 at 8:20 A.M., Licensed Practical Nurse (LPN) I said if there is an order for a UA, he/she would inform the DON, tell the Certified Nurse Aide (CNA) as well, so they can get the resident to pee in a urinal, hat, or he/she would get it him/herself. When it is collected, they put it in the refrigerator. If the resident was not able to give a urine sample, he/she will contact to the physician to see if they can strait cath. It would be documented. After a couple of tries to obtain the sample naturally, they will call the doctor, but they have to contact the doctor to strait cath. It is all documented. There is no policy for how many attempts or tries, but they try to see if it could be done that day. If not, he/she would pass it on to the next nurse, and they can try to get it that next shift. He/she would assess the resident for symptoms with the Registered Nurse (RN) to get another opinion and notify the physician if he/she saw more than one symptom of a UTI. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/16/24 at 8:40 A.M., the Director of Nursing (DON) said she worked at the facility since 7/1/24. When the nurse receives orders for a UA, nursing will attempt to get the UA. If they are unable to get a clean catch, they can strait cath. After one or two days they will notify the physician if unable to catch the urine. She would expect staff to document if the resident was not able to give a urine sample. The DON would expect the resident to be assessed and monitored for symptoms of pain/burning when urinating, flank pain, and abnormal discharge. If the UA was not completed and the resident has symptoms, the DON would expect nursing the contact the physician. The DON said if a UTI is not treated timely, it can affect the resident's urinary system, mentation, or they can become septic. Review of the resident's progress notes, showed: -On 6/6/24 at 2:50 P.M., resident exhibiting increased confusion and inability to bear weight. Resident displays difficulty navigating in his/her motorized wheelchair due to gross (large amount) bilateral lower extremity (BLE) edema (swelling) and weakness. Informed DON, Physical therapy (PT) to assessed and provide regular wheelchair. Resident's transfer status changed to Hoyer lift (full body mechanical lift) at this time. Call placed to physician's office to report and request order for lab work. Call placed to POA, message left; -On 6/6/24 at 3:44 P.M., call back from physician's office. Order obtained for Complete Blood Count (CBC, a blood test that measures the types and quantities of cells in your blood) and Basic Metabolic panel (BMP, test that measures several important aspects of your blood). Call placed to Lab and informed of need for draw. Phlebotomist will be out on next business day. Requisition completed. Call placed to RP, message left; -On 6/7/24 at 11:21 A.M., late entry: lab here for blood draw. Results pending; -On 6/8/24 at 7:28 P.M., resident requires assist with feeding. He/She is not able to use utensils. Resident has increased confusion, able to answer simple yes or no answers. RP informed of changes. Continue on antibiotic therapy for cellulitis (infection of the skin). Encourage fluids; -On 6/10/24 at 7:00 A.M., patient remains on close observation for antibiotic related to cellulitis. Zero complaints of pain or discomfort. Patient was resting in bed all night with eyes closed. Patient appeared to be sleep but easily awakened with call light in reach; -On 6/10/24 at 4:06 P.M., resident exhibits listlessness (a state of having little to no interest in anything, or a lack of energy), malaise (a general feeling of discomfort, uneasiness, or lack of well-being), and disorientation. Final lab results received. Many high and low values as well as critical results. Labs faxed and called to physician's office. Call back received from Physician L. Telephone orders received to send to emergency room for evaluation and treatment for abnormal labs. Call placed to daughter and informed. DON made aware. Call placed to local 911 for transport. Ambulance service had no available units; -On 6/10/24 at 5:02 P.M., Emergency medical service (EMS) in facility. Assumed care of resident. Report given. Exited facility in route to emergency room . Report called to nurse. Review of the resident's critical lab results, showed: (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	08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Collection date: 6/7/24 at 10:40 A.M.; -Received date: 6/7/24 at 4:00 P.M.; -Glucose showed 48, critical low (reference range/cut off 82-115); -BUN showed 59, critical high (reference range/cut off 8-23); -Bicarbonate (CO2) showed 13, critical low (reference range/cut off 22-29); -Originally reported on 6/7/24 at 5:25 P.M. During an interview on 8/15/24 at 11:48 A.M., the Administrator said they are looking into the resident's labs from 6/6/24 to see when it was reported. They ordered the labs and they were the ones that sent the resident out as well. They receive labs two ways, fax or electronic-fax. The e-fax goes to the Social Service Director. He/She will forward it to the person it goes to. During an interview on 8/15/24 at 11:23 A.M., Receptionist N from the lab company said lab results are sent through the portal and sent through email. It can also can be auto fax. The facility had settings for the results to be emailed as well. On the day the labs were completed, the results would be emailed on the day it was completed. The email address on file belonged to RN B. It was in the computer. The facility called earlier today and requested the same labs, so he/she sent them to the facility. During an interview on 8/15/24 at 11:52 A.M., RN B said the lab results used to come to his/her email, but not anymore. It was only for two months. It had been a few months since lab results were sent to his/her email. He/She could not recall if he/she received the resident's lab results via email. It was only a few times he/she was sent lab results, but he/she is always at the facility. Every now and then he/she will check his/her e-mail if he/she is off work. He/she checks his/her email first thing in the morning. Lab results also come to the fax as well. It can be faxed or emailed. Sometimes lab results go to the Assisted Living Facility (ALF) and staff bring them up. Lab results are faxed to the doctor. When critical lab results are received, staff call the physician and fax it to them. During an interview on 8/15/24 at 12:14 P.M., the Social Service Director said he/she receives lab results via electronic-fax. It comes directly to his/her computer and he/she prints them off and gives it to the appropriate department. It is checked daily. If he/she was off, it will come to his/her phone, and he/she sends it to the team. He/She did not receive an e-fax about the resident. Sometimes the results are sent to the Director of Nursing at the ALF and they bring it over to them. During an interview on 8/15/24 at 1:17 P.M., Licensed Practical Nurse (LPN) M said the results are faxed from the lab and he/she had access to look at the labs as well. The lab company will call the facility and fax any critical labs. If there's a critical lab, he/she will call the physician immediately and give the results. Physician L wanted the resident sent out. LPN M received a verbal order to send the resident out and he/she faxed the lab results. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/15/24 at 1:26 P.M., Receptionist O from the lab company said there was a phone call attempted on 6/7/24 between 5:30 P.M. and 5:45 P.M. with no answer. The facility has three fax numbers on file, the lab faxed the lab results to all three fax numbers between 5:26 P.M. and 5:27 P.M. The lab results are also uploaded to the online portal as soon as the results are completed. It is instant. There is also an email on file and the lab results were also emailed. He/she read the email address that belonged to RN B. The only confirmation he/she was able to see was it showed a status of completed. During an interview on 8/16/24 at 8:20 A.M., LPN I said if blood work was ordered, he/she would call the lab; however, they come every day. There is a bin at the nurse's station where the lab forms are kept. Nursing completes the form, what tests are needed, and they put it in the box. Staff will tell the person doing the lab if there is anything new. If they are not able to do the blood work for any reason, they will come back the next day and try again, but it is not usually a problem. Everything is documented. Once the lab test is completed, the facility receives the results via fax. There are no emails. If the lab result is critical, the lab will call, otherwise it is a fax. The fax machine is right outside the DON's office. The DON will document the lab results herself or bring them to nursing. The DON checks the fax or the nurse supervisor will check if the DON is not here. LPN I said he/she would check the fax for lab results when he/she makes copies or sends a fax his/herself. LPN I did not have access to the online portal. On the weekends, LPN I believed labs are faxed. The supervisor on the shift will check the fax. For critical labs, nursing is always expected to contact the physician. During an interview on 8/17/24 at 10:44 A.M., with LPN R, who worked on 6/7 and 6/9/24, he/she said he/she did not remember lab work being done or receiving labs that day. He/She was not told about the resident's lab. There were no lab results or critical labs that came when he/she worked. He/She always checked the printers which are either on the 2nd floor by the DON's office or the one downstairs. If they are waiting on labs that have not come back, they would call the lab. During an interview on 8/17/24 at 3:23 P.M., RN R confirmed he/she did not work on and never heard of any critical labs the weekend of 6/7 through 6/9/24. If they receive a fax, it varies on where it comes from. The lab sent it to different places: the ALF, right outside the door of DON's office, or 2nd floor fax. During an interview on 8/18/24 at 9:36 A.M., LPN T said if there were critical labs, he/she would have called it in. He/She would chart when labs came. Lately they have been e-faxed to the DON. They've had to call the lab to get them to fax results to the second floor nurse's station in the past. If they have not received labs in the appropriate timeframe, normally they will call the lab and wait for them to come. They will also follow up with the DON if they continue to have issues. LPN T did not recall receiving the labs on the weekend of 6/7 through 6/9/24. During an interview on 8/18/24 at 4:32 P.M., LPN U said he/she remembered the resident got labs, but he/she never saw the results. Generally, he/she does not receive results on the night shift, maybe x-ray results. No critical labs came in. He/She would have called them in. The labs that are faxed come across two machines. It is not at the nurse's station, but it is close to the medication room, and maybe one of the larger copy machines. Generally, during the night shift, they do not receive labs. If labs are not received timely, he/she would call over for them. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/19/24 at 8:11 A.M., LPN M said whenever the labs are critical, the lab always calls. He/She did not remember if they called or if he/she accessed the labs online. Once he/she received the labs, he/she called the doctor and there were orders to send the resident out. He/She did not remember if the labs were faxed or if he/she had to print them from the website. He/She left a detailed nurse's note. He/She contacted the physician as soon as there were critical labs. During an interview on 8/16/24 at 8:40 A.M., the DON said If there are orders for blood work, staff will complete the lab requisition, then call the lab, who is responsible for drawing the lab, so they know there is a blood draw when they come out. They do not come daily, so once the facility notifies them of a lab that needed to be drawn, they usually come out the next day. Everything is documented whether it can be done or not. Once the results are in, they are faxed to the facility. Sometimes it is faxed to the machine in reception or the nurse's station on the second floor. The DON does not have a fax. There is an internal fax that goes to an email, but she did not have access to that. There is someone at reception on the weekends. The social worker receives the email. Lab results does not come to the DON's email. The DON is not able to access the online portal. She had a log in, but it did not work, so she is in the process of getting access. Nursing is responsible for checking the fax machine and the receptionist checks the fax too. If there are critical labs, the lab will call. Critical labs are also faxed and emailed. When she spoke to the lab company, they said they will call and send it to the three fax numbers they have. Nursing is expected to call the physician and fax the lab results to the physician. If they do not get the physician right away, she would expect nursing to call back and relay a message. During the week, it is easier, but on the weekend, they would have to call the exchange. There is no formal process to ensure all labs are completed timely. The charge nurse knows who the lab is for and they usually follow up. She would expect for lab orders to be followed. If the UA or blood work was not completed, she would expect nursing to notify the physician. The DON did not have any knowledge of what happened with the lab results for the resident. She would expect nursing to contact the physician if a resident had a change in condition during the weekend. The resident's oxygen saturation should be checked and blood sugar as well, regardless if diabetic or not. The DON said the resident's glucose on the lab result would be considered low. The resident's lab results should had been addressed immediately. If staff cannot reach the physician, they can call the family and send the resident out to the emergency room for evaluation. During an interview on 8/16/24 at 10:14 A.M., the Social Worker for Physician L said on 6/6/24, the nurse practitioner ordered a BMP/CMP. On 6/10/24, it was reported to physician there were critical labs. They received labs at 3:15 P.M. that day. Physician L ordered to send the resident to the hospital due to critical labs. Staff are expected to call the physician for critical labs. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/16/24 at 12:29 P.M., the Administrator said she was not able to find the contract between the facility and the lab. They called the lab and asked for a copy. If staff are unable to catch urine on the first day or within 24 hours, physician notification is made to see what they would like to do. There should be increased assessment and observation for the reason they had a UA in the first place. The same with blood work, they should notify the physician. The results get faxed. The administrator was not aware of three separate fax numbers. She had seen lab results come to the main fax machine which is in reception and she became aware of an e-fax they send results to. Reception is here on the weekends, but checking the fax machine is the responsibility of nursing. She would expect nursing to check the fax at reception. If there are critical labs, the lab will call the facility and fax the results. They should call until they speak to someone. She would expect staff to notify the NP on 5/8/24 that the UA order was not able to be carried out. The NP should have been contacted much sooner and it should be documented. The administrator was not aware of the lab emailing the results, but there is a e-fax. It is a fax number, but it goes to an email. Nurse B was the former DON, but the administrator was not aware the email on file with the lab company belonged to Nurse B. She was not aware it was a routine practice that they were emailed. When the current DON started, the email should have been changed to her email. The Administrator does not receive any results. She would expect nursing to monitor symptoms of a UTI, including any odors, itching, redness, burning, flank pain, or no urine, and their temperature. She would want the resident to be assessed for all signs and symptoms. It should have documented the next day and staff should have notified the physician that next day if urine was not obtained. The administrator was not aware the resident's labs were sent on 6/7/24. She was trying to verify it. The report said reported, but they did not give a name, but she was not aware of the lab until the surveyor mentioned it. She would expect nursing to notify the physician timely for the labs. The administrator said the resident's critical labs should had been addressed immediately. MO00239805

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 34477 Based on observation and interview, the facility failed to ensure time/temperature controls for safety food (food that requires time/temperature control for safety to limit the growth of pathogens) were maintained at or below 41 degrees Fahrenheit (F) and freezer temperatures were maintained at a temperature to keep food frozen solid to prevent the potential for foodborne illnesses, failed to ensure the dishwasher in the main kitchen and in the dishwash room of the skilled nursing facility (SNF) were in working order, failed to ensure the sanitizer sink for the three compartment sink in the main kitchen was in working order to allow staff to properly sanitize dishes, and failed to ensure the handwash sinks in the first floor kitchenette and SNF dish room were in working order to allow staff to wash their hands to prevent cross-contamination. In addition, the facility failed to have thermometers available for staff to test the temperature of prepared foods. The facility also failed to maintain the overall cleanliness of the main kitchen and first and second floor kitchenette floors, walls, ceilings and equipment. Staff failed to keep open food items labeled, dated and sealed. Furthermore, the facility also failed to prevent the potential for cross contamination when staff left the flour scoop in the container in the main kitchen and stored the ice scoop on top the top shelf of steamtable in the first floor kitchenette. These deficient practices had the potential to affect all residents who ate at the facility. The census was 53. 1. Observation of the main kitchen on 8/13/24, showed: -At 9:55 A.M., the walk-in cooler door was propped open with an orange bucket. The temperature on the external thermometer read 50 F; -At 10:00 A.M., the walk-in cooler door remained open; -At 10:02 A.M., the Assistant Dietary Manager (ADM) and the Sous Chef (SC) were observed in the walk-in cooler unloading boxes. The door remained propped open. The external thermometer read 52 F; -The walk-in freezer within the walk-in cooler external thermometer read 10 F. Foods inside the walk-in freezer remained frozen solid. During an interview on 8/13/24 at 10:06 A.M., the ADM said it was her second day on the job. She was unsure why the door was propped open, but thought it had not been longer than 10-15 minutes. Observation on 8/13/24 at 10:07 A.M., showed the surveyor requested to take the temperature of an opened gallon of milk located on the bottom shelf, near the door of the walk-in cooler. Staff were unable to locate a thermometer to take the temperature. The ADM poured milk into a cup. The temperature was taken using the surveyor's thermometer and read 41.5 F. The ADM said the temperature should be less than 41 F. The ADM said she would throw out the milk and close the door to the walk-in cooler. Observation of the main kitchen on 8/13/24, showed: -At 10:51 A.M., the door to the walk-in cooler was propped open with an orange bucket; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The SC was inside the cooler with a laundry cart and was putting boxes of food into it; -The SC said they were expecting a food shipment today and needed to move frozen food the secondary freezer to make room. Observation on 8/13/24 at 10:58 A.M., showed the surveyor requested to take temperatures of food items stored in the walk-in cooler. The ADM gathered a small pan of pureed meat, an opened package of ham, and an opened container of cottage cheese. Using the surveyor's thermometer, the food temperatures, showed: -Pureed meat, 42.3 F; -Ham, 42 F; -Cottage cheese, 43.3 F; -During an interview, the ADM said any food items above the threshold of 41 F needed to be tossed out. She would begin temping the foods. Observation of the SNF kitchen on 8/13/24 from 11:11 A.M. to 11:30 A.M., showed: -The door of the walk-in cooler propped open with the laundry cart; -The SC unloaded boxes of frozen food into the cooler; -A reach-in freezer near the stove had a digital thermometer on the outside, which was blank and had no thermometer inside; -Two boxes of bacon. The boxes showed, keep refrigerated; -A box of turkey breakfast patties. The box showed, Keep frozen; -An open box of turkey sausage links. The box showed, Keep frozen. During an interview on 8/13/24 at 11:14 A.M., the SC said he assumed their should be a working thermometer for the reach-in freezer. He opened the door, touched one of the boxes of meat and said they felt cool. He said the Dietary Manager quit three weeks ago and he was in charge until the new Dietary Manager started. He did not know when that would be. He said he unloaded the boxes of food in the walk-in cooler because he did not know where another walk-in freezer was located. He needed to find it. Observation of the SNF walk-in cooler on 8/13/24 at 11:30 A.M., showed: -Two boxes of pasteurized whole eggs. The outside of the box showed Do not freeze; -Four boxes of fully baked yeast rolls. The outside of the box, showed Keep refrigerated' -A box of chocolate chip cookie dough; (continued on next page)

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	265735	A. Building B. Wing	08/19/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Two boxes of hard shell eggs; -A box of white bread. The outside of the box said Never refrigerate. Keep frozen; -Two opened boxes of frozen chicken wings. The box showed, Keep refrigerated or frozen; -Seven boxes of turkey sausage breakfast patties. The box showed, Keep frozen; -Four boxes of beef patties. The box showed, Keep frozen; -A box labeled pork loin. The box showed, Keep refrigerated or frozen; -A box of scrambled egg mix; -The external thermometer read 40 F. There was not an internal thermometer. Observation of the SNF kitchen on 8/13/24 at 1:37 P.M., showed: -The external thermometer on the walk-in cooler read 38 F; -The internal temperature of the walk-in cooler, taken with the surveyor's air thermometer, read 36 F; -The internal temperature of the reach-in cooler, taken with the surveyor's air thermometer, read 43.9 F. During an interview on 8/13/24 at 2:29 P.M. with the Administrator and ADM, the Administrator said she expected food to be stored at the proper temperature. The ADM said the food in the SNF walk-in cooler would be there temporarily. She took temperatures and it was ok. She did not know how long the food would be stored in the SNF. The Administrator said she expected staff to have and use thermometers. If they don't have thermometers, then they wouldn't be able to take food temps. The main kitchen should definitely have thermometers because that's where the residents' food was coming from. During an interview on 8/14/24 at 3:16 P.M., the Administrator said the ADM completed in-services with staff on keeping the cooler doors closed and maintaining proper food temperatures. She purchased thermometers for staff. Observation of the SNF kitchen on 8/15/24 at 10:46 A.M., showed: -The external thermometer of the walk-in cooler read 46 F; -An internal thermometer in the walk-in cooler, placed by the facility, read of 44 F; -An internal temperature in the walk in cooler, taken with the surveyor's air thermometer, read 43 F; -In addition to the food observed in the walk-in cooler on 8/13/24, five boxes of Mighty Shakes (nutritional supplement, which should remain frozen until ready to use) were in the walk-in cooler; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-An opened box of turkey sausage breakfast patties were soft to the touch; -An opened box of chicken wings were no longer frozen solid. Observation of the SNF reach-in freezer on 8/15/24 at 10:52 A.M., showed: -The exterior thermometer was blank; -An internal temperature, taken with the surveyor's air thermometer, read 39.6 F; -The boxes of bacon and sausages remained inside. Observation of the main kitchen on 8/15/24 at 10:57 A.M., showed: -Four dietary staff standing by the work table across from the walk-in cooler; -The walk-in cooler propped open with an orange bucket; -Food items on shelves had visible condensation; -Bags of shredded cheese and cartons of liquid eggs appeared to be bulging; -An internal temperature, taken with the surveyor's air thermometer, read 51 F. During an interview on 8/15/24 at 10:59 A.M., the ADM said she was not sure how long the door was propped open, but it shouldn't be. The door should remain closed so that the food coming out of it would not be harmful to anyone. If food was stored above 41 F it would be in the danger zone and not safe for consumption. It was everyone's responsibility to keep the door closed. Observation on 8/15/24 at 11:02 A.M., showed the surveyor requested to take temperatures of food items stored in the walk-in cooler. The ADM gathered a carton of yogurt on a shelf closest to the cooler door and a gallon of milk stored on a shelf approximately 2/3 of the way into the cooler. Using the ADM's thermometer, the food temperatures, showed: -Yogurt: 51.4 F; -Milk: 42.6 F. During an interview on 8/15/24 at 11:16 A.M., the ADM said she spoke with staff who were in the kitchen and no one knew who propped open the walk-in cooler door. During an interview on 8/15/24 at 11:58 A.M., the Administrator said she did two in-services with staff on the door being propped open. The outcome could be the potential to make someone sick. She would throw out the food in the SNF walk-in cooler and reach-in freezer. She would have the ADM throw out any food that exceeded 41 F in the main kitchen's walk-in cooler. 2. Observation of the main kitchen on all days of the survey from 8/12/24 through 8/16/24, showed the dishwash machine with a sign taped to the outside which read Out of Order 5/13/24. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 8/12/24 at 11:10 A.M., Dietary Aide (DA) V said he/she was responsible for washing the dishes. The dishwash machine had been broken for a while. He/She had to wash everything by hand in the three compartment sink. Observation of the main kitchen on 8/13/24 at 1:50 P.M., showed two DAs at the three compartment sink, washing dishes. DA X stood at the wash sink and after washing dishes, dunked the dishes in the rinse sink then handed to DA W. DA W then took the dishes and ran them under the faucet and a hose which was attached to the sanitizer container mounted on the wall. DA W then placed the dishes on the rack to dry. Review of the container of sanitizer on 8/13/24 at approximately 1:52 P.M., showed: Sanitizer one ounce to 16 gallons. Immerse all utensils for at least two minutes. During an interview on 8/13/24 at approximately 1:55 P.M., DA W said he/she was new and had been trained on how to wash dishes. DA W said the first step was to spray the dishes to remove any debris, then put in soapy water and wash. He/She would then rinse the dishes by running under the faucet and sanitizer hose. He/She would then put the dish on the rack to dry then put away. There was not a way to plug the sanitizer sink, so it could not be filled with sanitizer. Observation of the SNF dish room on 8/13/24 at 2:01 P.M., showed the right side of the dishwash machine with a heavy white and yellow build-up on the exterior. Standing water which was gray with white debris floating on top was inside the machine. There was an approximately half inch wide rust colored ring around the inside of the machine at the surface of the standing water. During an interview on 8/13/24 at 2:29 P.M., the Administrator said she was not aware the dish machine in the main kitchen did not work at all. She only knew staff were having challenges with it. She had asked the former Dietary Manager to obtain bids for repairs. She instructed staff to only wash pots and pans in the three-compartment sink. All other dishes were to be washed in the Assisted Living kitchenette. Staff should wash, rinse then sanitize when using the three-compartment sink. She was not sure how long dishes should be submerged in the sanitizer, but dishes should be submerged. She was not aware there was not a way to plug the sanitizer sink. It was important to sanitize dishes to prevent cross contamination. She was not aware of the condition of the dishwash machine in the SNF. During an interview on 8/14/24 at 3:16 P.M., the Administrator said the ADM completed in-services with staff on the proper way to use the three-compartment sink. The lever on the sanitize sink was repaired, so it could now be filled. A plug was also purchased as a back-up. The dishwash machine in the SNF was emptied and delimed. Observation and interview on 8/15/24 at 11:10 A.M., showed the three compartment- sink in the main kitchen had signs posted: wash, rinse, sanitize. DA V washed dishes. All three compartments were filled with soapy water. DA V said he/she was educated on the three-sink method. He/She said there should be soapy water in the wash first sink and bubbly water in the second and third sinks. 3. Observation of the first-floor kitchenette and dishwash room on 8/13/24, showed: -The kitchenette sink had no running water or soap; (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	08/19/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-At 7:44 A.M., DA Y entered the kitchenette and donned gloves. He/She then removed pans of food from the hot box and placed them onto the steam table. He/She grabbed a thermometer and then left the kitchenette. At 7:47 A.M., DA Y returned with alcohol wipes. He/She had on gloves. At 7:50 A.M., DA Y again left the kitchenette and returned with gloved hands. He/She then grabbed serving utensils and placed on the steam table. DA Y did not wash his/her hands upon entering the kitchenette; -The dishwash room sink was missing the faucet handle on the right side. The left side handle did not turn on the water. During an interview on 8/13/24 at 2:29 P.M., the Administrator said she expected staff to wash their hands when going from dirty to clean. She was not aware the water was not running in the handwash sinks. It was important for staff to wash their hands to prevent cross contamination and for infection control. Staff should have at least used hand sanitizer. She also expected staff do complete work orders for maintenance so things could be fixed. 4. Observation of the main kitchen on 8/12 through 8/15/24, showed: -Scraps of food, crumbs and debris on the floors; -The floors were slick with grease; -Food scraps ground into the rubber mats in the dish wash area; -Dust on and around seven out of nine ceiling vents; -The ceiling over the steam table had water stains and exposed dry wall that was cracked and chips were in the well of the steam table; -Splatter and dried spills on the walls by the work tables; -Heavy white build up on the floor around the ice-machine; -A thick build up of grease, dust and food particles were visible on the tops, fronts, sides and handles of the warmer, convection oven, stove and flat top; -The interior underneath the well of the deep fat fryer where the grease drain was located, had a brownish sticky build up on the inside of the door and all over the drain; -The table the stand up mixer was on had a reddish spill that was dried and covered with dust; -The floor of the walk in cooler had pieces of lettuce leaves and dried white spills; -The floor of the walk-in freezer had pieces of paper, a piece of cardboard and bits of ice; -The lids to the bulk food containers were sticky and covered in dust. The sides had dried splatter; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The base of the commercial food processor that attached to the bowl had caked on food particles and the sides were grimy; -The floors under the dish machine and the three-compartment sinks had whitish build-up and bits of trash; -Crumbs on the floor in the dry storage room. Observations of the first-floor kitchenette on 8/13 through 8/15/24, showed: -Heavy white and yellow build up around and under the ice machine; -Splatter on the walls; -Dust on the ceiling and around the vents; -Dust and food particles on the shelves under the steam table and work table; -Dried spills on the bottom of the reach-in refrigerator and freezer. Observations of the second-floor kitchenette on 8/14 through 8/16/24, showed a heavy white and yellow build up around and under the ice machine. During an interview on 8/15/24 at 11:20 A.M., the ADM said the floors should be clean. There should not be dust on the vents, but this should be done routinely by maintenance. The commercial food processor should not have food particles caked on it, to prevent cross contamination. The bulk bins should be clean. The large equipment and tables should be cleaned and sanitized. The deep fat fryer should not have a build up of grease because it was a potential fire hazard. The inside of refrigerators and freezers should be clean. The floors in the walk-in cooler and freezer should be clean. 5. Observations of the main kitchen on 8/12 through 8/15/24, showed: -In the dry storage room: -An open bag of muffin mix was not sealed or dated; -An opened bag of chocolate cake mix, wrapped in cling wrap, was not dated; -An opened bag of shredded coconut and an opened bag of powdered sugar, wrapped in cling wrap, were not dated; -An opened bag of yellow cake mix and an opened box of parboiled rice, wrapped in cling wrap, were not dated; -Three opened packages of pasta, wrapped in cling wrap, and undated; -Four wrapped sandwiches in the reach in cooler were undated; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Approximately 20 cups of various condiments in the reach in cooler were undated; -Five opened one gallon containers of various condiments in the walk-in cooler were undated; -A tray with six cups of chocolate ice cream were covered with plastic wrap and undated in the walk in freezer; -A pan with unidentifiable contents was covered in plastic wrap and did not have a label or date. Observations of the SNF kitchenettes, showed: -On 8/13/24 at 7:30 A.M., in the refrigerator, were an opened box with approximately 20 thawed Mighty shakes with a use by date of 8/15/24 and instructions to thaw and use within 14 days were undated and an opened box of thawed Ready Care shakes (nutritional supplement) with instructions to thaw and use in seven days, were undated; -On 8/14/24 at 8:44 A.M., in the reach-in was an undated, opened box of thawed Ready Care shakes. During an interview on 8/15/14 at 11:20 A.M., the ADM said opened food items should be labeled, dated and sealed, preferably in a zip lock bag, to ensure food was safe for consumption. 6. Observation of the main kitchen on 8/12/24 at 10:48 A.M., 8/13/24 at 10:18 A.M., showed a scoop inside the bulk flour container. Observation of the second-floor kitchenette on 8/14/24 at 8:44 A.M., showed the ice scoop on top of the steam table next to a bag of hot dog buns. During an interview on 8/15/24 at 11:20 A.M., the ADM said the scoops should be stored in holders to prevent cross contamination. 7. During an interview on 8/15/24 at 2:25 P.M., the Administrator said the floors, walls, ceilings and vents in all the dietary areas should be clean. All large equipment should be clean. Food should be labeled, dated and sealed.