

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265735	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/22/2026
NAME OF PROVIDER OR SUPPLIER Hidden Lake Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice when staff failed to transcribe physician orders resulting in missed medication changes and/or missed completion of labs for two residents (Residents #5 and #1). The sample was 8. The census was 63. Review of the facility's Transcription of Orders/Following Physician's Orders policy, dated 5/18/24, showed the following:-Purpose: The purpose of this policy is to outline procedures in accurately transcribing physician's orders and to ensure that all physician's orders are followed. To ensure a process is in place to monitor nurses in accurately transcribing and following physician's orders;-Policy:-Upon receiving a physician's order via telephone, fax, written order, verbal order, transcribed order or other, it will be documented in residents' electronic medical records (EMR) in orders section;-After laboratory testing, diagnostic testing or other services are ordered, the nurse will document orders in residents' EMR and fill out the corresponding requisition for the specific services to be obtained;-Clarification of physician's orders will be obtained if the order is either unclear or the nurse is uncomfortable in implementation of the physician's orders. 1. Review of Resident #5's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/8/26, showed the following:-No cognitive impairment;-Diagnoses included anemia (decrease in the number of red blood cells), high blood pressure, seizure disorder, anxiety, depression, and bipolar disorder (a chronic mental health condition characterized by extreme mood swings). Review of the resident's physician progress note, dated 4/9/26, showed plan/treatment included:-Routine labs including autoimmune profile (detects autoantibodies that cause the immune system to attack healthy tissue);-Start doxycycline (antibiotic) 100 milligrams (mg) twice daily for 10 days;-Discontinue the lithium (mood stabilizer) medication and check the resident's lithium level. Review of the resident's EMR, showed:-An active order, dated 4/2/26, for lithium carbonate (mood stabilizer) oral tablet extended release 450 mg, give one tablet by mouth two times a day;-No physician order for doxycycline or documentation of the medication being started, as directed by the physician progress note from 4/9/26;-No documentation of completion of routine labs or lithium level, as directed by the physician progress note from 4/9/26. During an interview on 4/20/26 at 1:10 P.M., the resident said he/she wanted to stop taking his/her lithium medication because it made him/her feel funny. During an interview on 4/22/26 at 8:40 A.M., Licensed Practical Nurse (LPN) A said he/she was not aware of the resident's physician orders from 4/9/26. He/She would review the resident's physician progress notes and would add the physician orders from the notes, which would include any medication orders changes and/or laboratory orders. During an interview on 4/22/26 at 9:20 A.M., LPN B said the Medical Director came in on 4/9/26 and all the physician's new orders were sent to the Director of Nursing (DON). To LPN B's knowledge, the DON deals with all the new physician orders and inputs them into the resident's electronic medical records. 2. Review of Resident #1's admission MDS, dated [DATE], showed the following:-No cognitive impairment;-Diagnoses included diabetes and depression. Review of the resident's physician's progress note, dated 3/19/26, showed plan/treatment included order routine laboratory studies for further evaluation. Review of the resident's EMR, showed:-No physician order for routine (continued on next page)</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>laboratory studies, as documented in the physician progress note from 3/19/26;-No completion of laboratory studies, as indicated by the physician progress note from 3/19/26. During an interview on 4/20/26 at 11:27 A.M., the resident said his/her physician ordered lab work but no one has come to do any type of blood draw. 3. During an interview on 4/21/26 at 9:00 A.M, the DON said she would review the physician progress notes for Residents #5 and #1 and would give the physician orders to the charge nurse to put into effect. She did not know what happened with the physician orders from the physician notes being missed and she did not know the orders were not followed. The routine labs mentioned in the physician progress notes meant full sets of labs, including complete blood count (CBC, determines general health status and screens for and monitors for a variety of disorders, including anemia) and comprehensive metabolic panel (measurement of blood sugar, electrolytes, fluid balance, kidney and liver function). 4. During an interview on 4/21/26 at 9:05 A.M., the Administrator said he expected the facility's policy to be followed. He did not know why the policy was not followed regarding physician orders. Today was the first time of him hearing about these issues with orders not followed. 29833612980383</p>		