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	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hidden Lake Health Care Center	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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure one resident (Resident #18) received adequate supervision and care to prevent accidents when one Certified Nurse Aide (CNA) failed to ensure two staff were present to assist during personal care, in accordance with the resident's care plan. While providing care, the CNA rolled the resident off the bed and onto the floor, resulting in the resident sustaining a fractured arm. The sample was 11. The census was 63. The Administrator was notified on 5/21/26 of the past non-compliance, which occurred on 5/8/26. The facility provided in-service training for all staff regarding the facility's resident bed mobility, transfer, and care policies. The deficiency was corrected on 5/8/26. Review of the facility's Fall Risk Assessment policy, revised 4/30/24, showed:-Purpose: It is the policy of this facility to provide an environment that is free from accident hazards over which the facility has control, and provide supervision and assistive devices to each resident to prevent avoidable accidents. -Policy:--The care plan will include interventions, including adequate supervision, consistent with a resident's needs, goals, and current standards of practice in order to reduce the risk of an accident; --Monitor the effectiveness of the care plan interventions, and modify the interventions as necessary, in accordance with current standards of practice. Review of Resident #18's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/9/26, showed the following:-Moderate cognitive impairment;-No moods or behaviors exhibited;-Dependent with activities of daily living (ADLs);-Diagnoses included anxiety disorder. Review of the resident's care plan, in use at the time of survey, showed the following:-Focus: Resident has an ADL self-care performance deficit with regards to pain due to degenerative joint disease and lumbar spinal stenosis (a common condition where the spinal canal, which contains the nerve roots and spinal cord, becomes compressed);-Interventions included resident requires assistance of two staff to turn and reposition in bed as necessary. Review of the resident's nurse's note, dated 5/8/26 at 10:21 A.M., showed Licensed Practical Nurse (LPN) A documented the CNA notified this nurse the resident was on the floor. Upon entering the room, the resident was lying face down with both of his/her arms flexed under his/her body. A puddle of blood was noted under the resident's face. The resident's physician was made aware of the incident and received an order to send resident to hospital for further evaluation. The resident's nose was noted to have a pinpoint opening and a drop of blood coming out once cleaned. The resident's nose was noted to be swollen, but the resident denied any pain. The resident moved his/her legs and allowed this nurse to move both arms. The resident said he/she was in a little pain but he/she was alright. The resident showed slight usual discomfort to his/her right upper extremity. The resident was lifted on Hoyer (mechanical lift) device and showed no signs of pain or discomfort. The resident was put in bed and CNA turned the resident to the right to put his/her diaper on and the resident screamed. When asked where it hurt, the resident pointed to his/her right arm. Emergency Medical Services (EMS) arrived and made aware of all of the above. EMS left with resident at 10:05 A.M. Review of the resident's hospital record, dated 5/8/26, showed the resident was sent to the emergency room due to right arm pain and bloody nose. Of note, the resident resides at a nursing facility. The resident said the nurse was telling him/her to roll over and he/she rolled (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	over and fell out of bed, landing on his/her right side, hitting his/her face and head. An x-ray to the right elbow showed mildly displaced communicated fracture (bone fractured into two more pieces) of the right distal (situated farthest form the center or point of attachment) humerus (long bone in the upper arm). A computed tomography (CT) scan showed comminuted fracture of the right distal humerus with extensive soft tissue swelling/ill-defined hematoma surrounding the elbow and extending into the forearm. Observation on 5/21/26 at 9:48 A.M., showed the resident in bed with a sling on his/her right arm, working with a Physical Therapist (PT). During an interview on 5/21/26 at 10:53 A.M., LPN A said CNA B notified him/her of the incident with the resident. CNA B said when he/she was changing the resident in bed, he/she rolled the resident over and the resident fell out of the bed. The resident was supposed to be a two-person assist in bed. CNA B could have reviewed the nurses reference book to see the resident's care needs. Review of the facility's nurse reference book, located at the second floor nursing station, reviewed on 5/21/26, showed the resident was a two-person assist with care. During an interview on 5/21/26 at 10:59 A.M., CNA B said he/she provided care to the resident alone. He/She rolled the resident onto his/her right side and the resident rolled out of the bed and onto the floor. CNA B did not know the resident was a two-person assist with care. The residents used to have a note about their care needs on the inside of their closet, but those are no longer there. During an interview on 5/21/26 at 11:05 A.M., the Director of Nursing (DON) said the CNA should have reviewed the nursing reference book to review the resident's care needs. After the incident, she in-serviced all staff on using a two-person assist and bed mobility. During an interview on 5/21/26 at 12:25 P.M., the Administrator said he was aware the DON in-serviced all staff on using a two-person assist and bed mobility on 5/8/26. He expected staff to follow the resident's care plan and to have used two-person assist. 3020430