Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32203	A. BUILDING: _____ B. WING _____	C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSLAND WALK SENIOR LIVING	868 KINGSLAND AVE SAINT LOUIS, MO 63130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4724	19 CSR 30-86.047(19) TB Screen Residents & Staff The facility shall screen residents and staff for tuberculosis as required for long-term care facilities by 19 CSR 20-20.100. II This regulation is not met as evidenced by: Based on interview and record review, the facility failed to ensure the required two step tuberculosis (TB) test was completed prior to hire and an annual one step or screening was completed, for two sampled employees. The census was 59. General requirements for TB testing for staff in Long Term Care Facilities, 19 CSR 20-20.100, reads as follows: -Long-term care facilities shall screen their staff for tuberculosis. Each facility shall be responsible for ensuring that all test results are completed, and that documentation is maintained; -Within one month prior to starting employment, all new to long-term care employees are required to have the initial test of a two-step TB test; -All employees and volunteers are required to obtain Mantoux PPD (purified protein derivative) two-step TB test within one month prior to starting employment in the facility. If the initial test is zero to nine millimeters (mm), the second test should be given three weeks after employment begins, unless documentation is provided indicating a PPD test in the past and at least one subsequent annual test within the past two years; -If the initial test is negative, the second test should be given as soon as possible within one to three weeks after employment begins. The CDC states TB tests should be read 48 to 72 hours after administration; -All positive findings shall require a chest X-ray to rule out active pulmonary disease; -Individuals with a positive finding need not have	A4724		

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A4724	Continued From page 1 repeat annual chest X-rays. They shall have a documented annual evaluation to rule out signs and symptoms of tuberculosis disease. 1. Review of Employee A's personnel record, showed the following: -Hire date 5/10/23; -An annual TB/PPD dated 1/17/25, with a read on date of 1/29/25, and findings of 0 mm; -No documented annual TB/PPD for 1/2026. 2. Review of Employee D's personnel record, showed the following: -Hire date 1/2/25; -A chest x-ray dated 10/2/23, with no findings of TB/PPD; -No documented TB/PPD screening dated 10/2024 or 10/2025. 3. During an interview on 4/22/26 at 2:15 P.M., the Director of Nursing said she is responsible for tracking and keeping staff up to date on their TB. She expected them all to have an annual test or screening if they had a chest x-ray. She said she knew the TBs were being completed but she did not know there were team members that were past due. 4. During an interview on 4/22/26 at 2:18 P.M., the Administrator said she was aware of the regulation, but was not aware they were out of compliance. She expected them to be completed.	A4724		
A4755	19 CSR 30-86.047(28)(H) Individual Service Plan - Review Requirements The facility may admit or retain an individual for residency in an assisted living facility only if the individual does not require hospitalization or	A4755		

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A4755	Continued From page 2	A4755		

skilled nursing placement as defined in this rule, and only if the facility:
(H) Reviews the ISP with the resident, or legal representative of the resident, at least annually or when there is a significant change in the resident ' s condition which may require a change in services; II

This regulation is not met as evidenced by:
Based on interview and record review, the facility failed to review a resident's individualized service plan (ISP) to include updates following a fall, details on what kind of assistance a resident required, protective measures put in place after a change of condition and behavior of a resident, and when a resident had a wound and the ISP did not explain who would treat the wound and when to treat the wound, for four of six sampled residents (Residents #3, #4, #1 and #6). The census was 59.

1. Review of Resident #3's medical record, showed the facility admitted the resident on 7/14/21, with diagnoses which included dementia with behavioral disturbance, chronic migraine, asthma, insomnia and anxiety.

Review of the resident's progress notes, showed the following:
-On 9/6/25 at 10:56 A.M., the staff heard yelling from the medication room and saw a resident walking, holding his/her face. A staff member said the resident struck that resident (the one walking). The resident tried to get the other resident's walker and that resident would not let go, so the resident struck him/her. The two residents were separated to do an activity. There were no visible bruises or bleeding, and the Director of Nursing (DON) was notified;
-On 1/5/26 at 9:35 P.M., staff found the resident

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A4755	Continued From page 3	A4755		

on the floor sitting by his/her bed. The resident said he/she sat down on the floor. Staff took the resident's vitals, and range of motion was completed. There was no sign of pain or bruising. Staff left a message for the family member, and notified the DON;
-On 1/6/26 at 5:42 P.M., the resident was very aggressive towards other residents. He/she took his/her medication out of his/her mouth and tried to give the medication to another resident. The staff member tried to get the medication from the resident, but the resident would not give the medication back. The staff member finally got the resident to give the medication to him/her. The resident had been more aggressive during dinner time.

Review of the resident's ISP dated 1/29/26, showed the following:
-Need: A.M., Routine: The resident required assistance with dressing. The staff should help assist the resident with brushing his/her teeth and getting him/her out for breakfast;
-Need: Activities assistance. The staff were to encourage the resident to attend social settings. The staff were to do daily walks with the resident as an activity.

Review of the resident's progress note dated 2/28/26 at 2:52 P.M., showed the resident was bending down trying to pick something off the floor when he/she lost his/her balance. The staff approached the resident after the fall, and the resident became very aggressive and combative and started to hit the staff member. The staff member attempted to take the resident's vitals, but the resident refused. The staff member notified the Nurse as well as the resident's family member.

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A4755	Continued From page 4	A4755		

Review of the resident's ISP dated 1/29/26, showed the following:
-The ISP did not address the resident's most recent falls and new interventions to prevent future falls;
-The ISP did not address the resident's aggressive behavior towards other residents and staff;
-The ISP did not explain what kind of assistance the resident required with dressing.

2. Review of Resident #4's medical record, showed the facility admitted the resident on 4/26/25, with diagnoses which included high blood pressure and breast cancer.

Review of the resident's progress notes, showed the following:
-On 3/11/26 at 3:42 P.M., the Licensed Practical Nurse (LPN) wrote wound measurements were done to the resident's right breast amputation site. The measurements were 9.5 centimeter (cm) by 4.3 cm by 0.3 cm undermining. Slough (yellow/white dead tissue) was noted to wound bed. The wound edges were rolled. The surrounding skin was red, dry and flaky. There was purulent (pus) drainage noted to the wound. There was an odor to the wound. The LPN notified the resident's Physician. There were new orders for Bactrim (antibiotic used to treat bacterial infections) and restart using Dakin's (wound cleanser) to cleanse wounds. The LPN called the resident's power of attorney (POA) but was unable to leave a message;
-On 3/20/26 at 2:46 P.M., a Care Partner (CP) informed the Medication Aide (MA) the resident needed help getting off the floor. The resident told the CP he/she fell and hit his/her head on the nightstand. After helping the resident off the floor, staff took the resident's vitals. The resident said

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A4755	Continued From page 5	A4755		

he/she was okay. Staff informed the DON, who said to send the resident out. The resident's POA was called but no answer, so a voice message was left. The Paramedics appeared and took the resident's vitals a second time. The resident refused to go to the hospital. The Paramedics asked the resident questions about his/her fall and the resident answered the questions. The resident was in bed resting quietly and had been checked on periodically until the end of shift;
-On 3/25/26 at 10:30 P.M., an LPN wrote the wound measurements were done to the resident's right breast amputation site. The wound measured 9.5 cm by 4.5 cm by 0.5 cm undermining. Slough was noted to the wound bed. The wound edges rolled. No odor to the wound;
-On 3/31/26 at 4:33 A.M., an MA wrote when answering the resident's call light, the MA found the resident on the right side of the bed (between the bed and nightstand) on the floor. The resident said he/she fell out of bed and hit his/her face and head on the nightstand. The MA observed an abrasion on the resident's right eye/temporal area and left arm. The MA asked the resident if he/she was in any pain and the resident said no. The MA informed the DON who instructed the MA to call Paramedics. Paramedics arrived and assisted the resident off the floor, onto a stretcher and then to the hospital. The MA called the resident's POA and left a message;
-On 3/31/26 at 1:26 P.M., the resident returned from the hospital after having a fall earlier in the morning. The resident was returned via cab. The resident walked into the community with a steady gait and denied any pain or discomfort upon return. The resident had a small laceration above his/her right eye and a skin tear to his/her left elbow area;
-On 4/1/26 at 3:36 P.M., an LPN measured the

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A4755	Continued From page 6 resident's right breast amputation site. The wound measured 9.3 cm by 4.5 cm by 0.4 cm undermining. The wound bed was noted to have slough. There was no drainage noted to the wound. No odor was noted. The surrounding skin was dry and rolled. The resident denied pain or discomfort. There were no signs or symptoms of distress noted; -On 4/7/26 at 6:44 A.M., an MA answered the resident's call light. The MA found the resident on the floor by his/her nightstand and bed, with his/her back toward the wall sitting on his/her bottom with his/her legs out in front of him/her and his/her walker by his/her commode. The resident said he/she slipped off the bed again this morning for a second time. The resident said he/she hit his/her head. There was no sign of bleeding. No noticeable bump. The resident said he/she did not want to go to the hospital. Further range of motion was performed per the Nurse's guidance. Another MA came into the resident's room to help the resident off the floor. The two MA's put the resident in his/her chair on the other side of his/her bed. No vitals were taken at this time. The resident complained about both of his/her knees. The MA gave him/her pain medication. The Nurse was notified prior to getting the resident up and a message was left with the resident's POA; -On 4/7/26 at 2:01 P.M., an LPN wrote the resident's dressing came off to right breast amputation site. The wound measurements were done. The wound measured 9.5 cm by 4.5 cm by 0.5 cm undermining. Slough was noted to the wound bed. No odor was noted. The wound dressing was reapplied. The resident said he/she did not want to go to the hospital. The resident was encouraged to drink water. The resident's Physician said he/she would be there to see the resident.	A4755		

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A4755	Continued From page 7 Review of the resident's ISP dated 4/7/26, showed the following: -Need: Wound care - dependent: the resident had a wound to his/her right breast amputation site. The wound care would be monitored by the community Nurses and the wound company. The prescribed wound care orders would be followed and noted; -Fall intervention: On 3/31/26, the resident fell out of bed while sleeping. The staff were to do wellness checks throughout the night. On 4/7/26, the resident fell out of bed. The staff were to encourage the resident to move all blankets out of the way before standing; -Need: Toileting - minimal assistance. The resident was incontinent of bowel and bladder. The staff were to assist the resident with toileting needs. The resident would remain dry, clean and free from odor. No skin breakdown due to incontinence will occur through the next review. Review of the resident's progress notes dated 4/11/26 at 3:45 A.M., showed a CP wrote the resident sat on the floor saying he/she slid down. The CP asked if the resident was hurt and the resident said no. The CP completed range of motion and asked the resident for help getting him/her back to help. The Nurse was notified. During an interview on 4/22/26 at 10:52 A.M., MA F said the resident would get "really combative" around dinner time. The MA said the resident would try to feed other residents. The MA said after the resident would take his/her medication, later on, the resident would repeatedly ask for his/her medication, forgetting he/she already took the medication. Review of the resident's ISP dated 4/7/26,	A4755		

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A4755	Continued From page 8	A4755		

showed the following:
-The ISP did not explain what kind of assistance the resident required with toileting;
-The ISP did not address the most recent falls the resident had with new interventions for each fall to prevent future falls;
-The ISP did not address who was responsible for the resident's wound if the wound company was not able to come to the facility;
-The ISP did not address the resident trying to feed other residents and combativeness.

3. Review of Resident #1's medical record, showed the facility admitted the resident on 6/21/23, with diagnoses which included Alzheimer's, dementia with behavioral disturbance, high blood pressure and kidney disease.

Review of the resident's progress notes dated 3/17/26 at 1:15 A.M., showed staff found the resident on the side of his/her bed in a fetal position. Staff asked what happened and the resident said he/she was looking for his/her insurance man and fell out of bed. Staff asked the resident if they were okay and if the resident had hit his/her head. The resident said no and staff noted no obvious signs of pain or bruising. The staff did a range of motion test and then helped the resident off the floor back into bed. The note also included the DON was notified.

Review of the resident's ISP dated 1/23/26, showed Need: Transfer to/from bed: Totally dependent. The resident needed minimal assistance when getting to and from bed. The resident preferred to transfer to and from bed alone. Staff were to assist when transferring to and from bed with gait belt. The ISP had no documentation of any falls.

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A4755	Continued From page 9 During an interview on 4/22/26 at 12:38 P.M., MA A said he/she did notify the DON about the fall but he/she could not remember if it was verbally or by phone. MA A said he/she checked his/her phone and did not show a call so he/she must have said something to the DON at some point. During an interview on 4/22/26 at 11:47 A.M., the DON said she was not notified of any fall for the resident or it would have been on the ISP. 4. Review of Resident #6's medical record, showed the facility admitted the resident on 6/30/23, with diagnoses which included diabetes, Alzheimer's disease, high blood pressure, and chronic kidney disease. Review of the resident's ISP dated 1/15/26, showed the following: -Need: Bladder and bowel incontinence- Staff to assist the resident in maintaining his/her cleanliness and helping him/her regularly with toileting. The resident was able to feel the urge to go to the bathroom, however, did have frequent incidents where he/she was unable to make it to the bathroom in time. Staff were to provide incontinence care at those times. The resident did wear adult pull ups, and the staff was to ensure the resident had fresh pull-ups on and clean pants as needed; -Need: Safety- the resident has no history of falls. Review of the resident's progress notes, showed the following: -On 4/8/26 at 5:07 P.M., MA A noted LPN I was going into the resident's room to work with him/her when he/she found the resident on the floor, seated on his/her bottom by the bathroom entrance. The resident's walker was turned over	A4755		

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A4755	Continued From page 10	A4755		

by the bathroom, and his/her pendant was on his/her neck but he/she did not use it. MA A and LPN I assisted the resident off the the floor, range of motion was performed, there were no signs of bleeding or bruising. The resident was assisted into his/her wheelchair. Vitals were taken. Family was called and notified;
-On 4/13/26 at 11:53 P.M., MA H noted when he/she was passing medications to the resident he/she entered the apartment and found the resident in the bathroom between the toilet and the shower on the floor. He/she asked the resident what happened and the resident said he/she slipped while trying to sit on the toilet. The resident's walker and wheelchair were found on the other side of the room and MA H asked the resident if he/she was in any pain. The resident said yes his/her back, hip, and knee hurt. MA H notified the DON who instructed for the resident to be sent to the hospital. MA H called 911 and the resident was sent to the hospital. The resident's son was notified.

Review of the resident's ISP dated 1/15/26, did not address the resident's falls or interventions on how to prevent falls from occurring in the future.

5. During an interview on 4/22/26 at 2:40 P.M., the DON said she puts the date a fall occurred, where the fall occurred, and an intervention. She said she expected falls to be included on the ISP. Herself or the other nurse would have been responsible to update the ISP with interventions. She expected any assistance needed by a resident to be included on the ISP, and the directions for assistance should be spelled out. She said it should be spelled out for anyone who provides care.

6. During an interview on 4/22/26 at 2:43 P.M.,

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A4755	Continued From page 11 the Administrator said she expected to see the falls on the ISPs with interventions and the care spelled out. She was not aware the ISPs did not include the information.	A4755		
A4797	19 CSR 30-86.047(46) Safe & Effective Medication System The administrator shall develop and implement a safe and effective system of medication control and use, which assures that all residents ' medications are administered by personnel at least eighteen (18) years of age, in accordance with physicians ' instructions using acceptable nursing techniques. The facility shall employ a licensed nurse eight (8) hours per week for every thirty (30) residents to monitor each resident ' s condition and medication. Administration of medication shall mean delivering to a resident his or her prescription medication either in the original pharmacy container, or for internal medication, removing an individual dose from the pharmacy container and placing it in a small cup container or liquid medium for the resident to remove from the container and self-administer. External prescription medication may be applied by facility personnel if the resident is unable to do so and the resident ' s physician so authorizes. All individuals who administer medication shall be trained in medication administration and, if not a physician or a licensed nurse, shall be a certified medication technician or level I medication aide. I/II This regulation is not met as evidenced by: Class II Based on interview and record review, the facility	A4797		

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A4797	Continued From page 12	A4797		

failed to provide a safe and effective medication system when a staff member who was not qualified to pass medications administered medication to six residents (Residents #7, #8, #9, #6, #10, and #11) during the morning medication pass. Additionally, the facility failed to have a system in place to ensure staff maintained an appropriate certification to administer medications to residents. The census was 59.

1. Observation of the morning medication pass, showed the following:
-At 7:46 A.M., Medication Aide (MA) A obtained Resident #7's blood sugar level and administered 15 units of insulin (used to treat diabetes);
-At 7:48 A.M., MA A administered 11 oral medications to Resident #8;
-At 7:55 A.M., MA A administered seven oral medications and two nasal spray medications to Resident #9;
-At 8:01 A.M., MA A administered eye drops to Resident #6;
-At 8:02 A.M., MA A administered seven oral medications to Resident #10;
-At 8:12 A.M., MA A administered five oral medications to Resident #11.

2. Review of MA A's employee file, showed the following:
-Date of hire 5/10/23;
-L1MA certificate expired on 3/8/26;
-No documentation that a renewed state licensed certification of L1MA was obtained.

3. During an interview on 4/22/26, MA A said usually the Nurse Practitioner that awarded him/her the certificate for his/her L1MA calls to remind him/her to renew it. He/she said he/she was not aware it had expired.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32203	A. BUILDING: _____ B. WING _____	C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSLAND WALK SENIOR LIVING	868 KINGSLAND AVE SAINT LOUIS, MO 63130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4797	Continued From page 13 4. During an interview on 4/22/26 at 2:20 P.M., the Administrator said the individual is responsible for tracking their own license, but the facility's human resources person would be responsible for follow up. She said she was not aware MA A's certificate had expired.	A4797		
A4798	19 CSR 30-86.047(47)(A) Physicians Orders Followed Medication Orders. (A) No medication, treatment or diet shall be administered without an order from an individual lawfully authorized to prescribe such and the order shall be followed. II/III This regulation is not met as evidenced by: Class II* Based on interview and record review, the facility failed to ensure all Physician's orders sheets (POS) were followed when treatments were not given as ordered, for one of six sampled residents (Resident #4). The census was 59. Review of Resident #4's medical record, showed the facility admitted the resident on 4/26/25, with diagnoses which included high blood pressure and breast cancer. Review of the resident's progress notes, showed the following: -On 3/11/26 at 3:42 P.M., the Licensed Practical Nurse (LPN) wrote wound measurements were done to the resident's right breast amputation site. The measurements were 9.5 centimeter (cm) by 4.3 cm by 0.3 cm undermining. Slough (yellow/white dead tissue) was noted to wound bed. The wound edges were rolled. The	A4798		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32203	A. BUILDING: _____ B. WING _____	C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSLAND WALK SENIOR LIVING	868 KINGSLAND AVE SAINT LOUIS, MO 63130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4798	Continued From page 14 surrounding skin was red, dry and flaky. There was purulent (pus) drainage noted to the wound. There was an odor to the wound. The LPN notified the resident's Physician. There were new orders for Bactrim (antibiotic used to treat bacterial infections) and restart using Dakin's (wound cleanser) to cleanse wounds. The LPN called the resident's power of attorney (POA) but was unable to leave a message; -On 3/20/26 at 2:46 P.M., a Care Partner (CP) informed the Medication Aide (MA) the resident needed help getting off the floor. The resident told the CP he/she fell and hit his/her head on the nightstand. After helping the resident off the floor, the resident's vitals were taken. The resident said he/she was okay. The Director of Nursing (DON) was informed and said to send the resident out. The resident's POA was called but no answer, so a voice message was left. The Paramedics appeared and took the resident's vitals a second time. The resident refused to go to the hospital. The Paramedics asked the resident questions about his/her fall and the resident answered the questions. The resident was not in bed resting quietly and had been checked on periodically until the end of shift; -On 3/25/26 at 10:30 P.M., an LPN wrote the wound measurements were done to the resident's right breast amputation site. The wound measured 9.5 cm by 4.5 cm by 0.5 cm undermining. Slough was noted to the wound bed. The wound edges rolled. No odor to the wound; -On 3/31/26 at 4:33 A.M., an MA wrote when answering the resident's call light, the MA found the resident on the right side of the bed (between the bed and nightstand) on the floor. The resident said he/she fell out of bed and hit his/her face and head on the nightstand. The MA observed an abrasion on the resident's right eye/temporal area	A4798		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32203	A. BUILDING: _____ B. WING _____	C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSLAND WALK SENIOR LIVING	868 KINGSLAND AVE SAINT LOUIS, MO 63130

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A4798	Continued From page 15 and left arm. The MA asked the resident if he/she was in any pain and the resident said no. The MA informed the DON who instructed the MA to call Paramedics. Paramedics arrived and assisted the resident off the floor, onto a stretcher and then to the hospital. The MA called the resident's POA and left a message; -On 3/31/26 at 1:26 P.M., the resident returned from the hospital after having a fall earlier in the morning. The resident was returned via cab. The resident walked into the community with a steady gait and denied any pain or discomfort upon return. The resident had a small laceration above his/her right eye and a skin tear to his/her left elbow area; -On 4/1/26 at 3:36 P.M., an LPN measured the resident's right breast amputation site. The wound measured 9.3 cm by 4.5 cm by 0.4 cm undermining. The wound bed was noted to have slough. There was no drainage noted to the wound. No odor was noted. The surrounding skin was dry and rolled. The resident denied pain or discomfort. There were no signs or symptoms of distress noted; -On 4/7/26 at 6:44 A.M., an MA answered the resident's call light. The MA found the resident on the floor by his/her nightstand and bed with his/her back toward the wall sitting on his/her bottom with his/her legs out in front of him/her and his/her walker by his/her commode. The resident said he/she slipped off the bed again this morning for a second time. The resident said he/she hit his/her head. There was no sign of bleeding. No noticeable bump. The resident said he/she did not want to go to the hospital. Further range of motion was performed per the Nurse's guidance. Another MA came into the resident's room to help the resident off the floor. The two MA's put the resident in his/her chair on the other side of his/her bed. No vitals were taken at this	A4798		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32203	A. BUILDING: _____ B. WING _____	C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSLAND WALK SENIOR LIVING	868 KINGSLAND AVE SAINT LOUIS, MO 63130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4798	Continued From page 16	A4798		

time. The resident complained about both of his/her knees. The MA gave him/her pain medication. The Nurse was notified prior to getting the resident up and a message was left with the resident's POA;
-On 4/7/26 at 2:01 P.M., an LPN wrote the resident's dressing came off to right breast amputation site. The wound measurements were done. The wound measured 9.5 cm by 4.5 cm by 0.5 cm undermining. Slough was noted to the wound bed. No odor was noted. The wound dressing was reapplied. The resident said he/she did not want to go to the hospital. The resident was encouraged to drink water. The resident's Physician said he/she would be there to see the resident.

Review of the resident's Physician's orders sheet dated 4/2026, showed the resident had a treatment order to cleanse area on right breast with Dakins (wound cleanser). Apply mupirocin (antibiotic cream). Apply Dakins soaked gauze. Apply calcium alginate (wound cleanser) topically to right breast. Cover with gauze and secure with tape. Change three times weekly.

Review of the resident's treatment administration record, showed the following:
-On 4/1/26, no documentation on whether the treatment was completed or not;
-On 4/3/26, no documentation on whether the treatment was completed or not;
-On 4/6/26, no documentation on whether the treatment was completed or not;
-On 4/8/26, no documentation on whether the treatment was completed or not;
-On 4/10/26, no documentation on whether the treatment was completed or not;
-On 4/13/26, no documentation on whether the treatment was completed or not;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32203	A. BUILDING: _____ B. WING _____	C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSLAND WALK SENIOR LIVING	868 KINGSLAND AVE SAINT LOUIS, MO 63130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4798	Continued From page 17 -On 4/15/26, no documentation on whether the treatment was completed or not; -On 4/17/26, no documentation on whether the treatment was completed or not; -On 4/20/26, no documentation on whether the treatment was completed or not. During an interview on 4/22/26 at 1:45 P.M., the Director of Nursing (DON) said the previous Nurse measured the wound frequently. She said the wound company was short staffed and sometimes would not show so the previous Nurse would treat the wound. She said the previous Nurse should have documented the treatment on the treatment administration record. She said she did not have a way to prove the treatment was done without the documentation being completed. *The higher the classification merited due to the extent of the violation.	A4798		
A4837	19 CSR 30-86.047(58)(B) Resident Condition/Medication Review The facility shall maintain a record in the facility for each resident, which shall include the following: (B) A review monthly or more frequently, if indicated, of the resident ' s general condition and needs; a monthly review of medication consumption of any resident controlling his or her own medication, noting if prescription medications are being used in appropriate quantities; a daily record of administration of medication; a logging of the medication regimen review process; a monthly weight; a record of each referral of a resident for services from an outside service; and a record of any resident incidents including behaviors that present a	A4837		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32203	A. BUILDING: _____ B. WING _____	C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSLAND WALK SENIOR LIVING	868 KINGSLAND AVE SAINT LOUIS, MO 63130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4837	Continued From page 18 reasonable likelihood of serious harm to himself or herself or others and accidents that potentially could result in injury or did result in injuries involving the resident; III This regulation is not met as evidenced by: Based on interview and record review, the facility failed to ensure all accidents and incidents were documented in a resident's chart when a resident had an unwitnessed fall in the morning, but it was not documented in the resident's chart, for one of six sampled residents (Resident #4). The census was 59. Review of Resident #4's medical record, showed the facility admitted the resident on 4/26/25, with diagnoses which included high blood pressure and breast cancer. Review of the resident's progress note dated 4/7/26 at 6:44 A.M., showed a Medication Aide (MA) answered the resident's call light. The MA found the resident on the floor by his/her nightstand and bed, with his/her back toward the wall sitting on his/her bottom with his/her legs out in front of him/her and his/her walker by his/her commode. The resident said he/she slipped off the bed again this morning for a second time. The resident said he/she hit his/her head. There was no sign of bleeding. No noticeable bump. The resident said he/she did not want to go to the hospital. Further range of motion was performed per the Nurse's guidance. Another MA came into the resident's room to help the resident off the floor. The two MA's put the resident in his/her chair on the other side of his/her bed. No vitals were taken at this time. The resident complained about both of his/her knees. The MA gave	A4837		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32203	A. BUILDING: _____ B. WING _____	C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSLAND WALK SENIOR LIVING	868 KINGSLAND AVE SAINT LOUIS, MO 63130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4837	Continued From page 19 him/her pain medication. The Nurse was notified prior to getting the resident up and a message was left with the resident's POA. During an interview on 4/22/26 at 11:29 A.M., Medication Aide (MA) A said the resident had two falls on 4/7/26. The fall at 6:44 A.M., was his/her second fall. MA A said the resident fell around 4:00 A.M., prior to the fall before 6:44 A.M. The MA did not know how the resident fell but said MA E was at the facility when the resident fell at 4:00 A.M. During an interview on 4/22/26 at 1:37 P.M., MA E said the resident fell around 4:00 A.M. on 4/7/26. The MA said the resident was found on the floor near the bed and the nightstand. The MA said he/she called the Director of Nursing (DON) who assessed the resident over the phone. The MA said he/she thought a note was created in the resident's progress notes, but the system was not working right, and he/she was new. The MA said the progress note must not have saved. The MA said he/she or someone else should have checked later to make sure the note was created. During an interview on 4/22/26 at 2:19 P.M., the Administrator said all falls, incidents and accidents should be documented in the resident's chart. She said someone should have gone back and made sure the documentation on the fall was completed.	A4837		
A4841	19 CSR 30-86.047(61)(A) Staffing Ration, Resident Care & Fire Safety Staffing Requirements. (A) The facility shall have an adequate number and type of personnel for the proper care of	A4841		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32203	A. BUILDING: _____ B. WING _____	C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSLAND WALK SENIOR LIVING	868 KINGSLAND AVE SAINT LOUIS, MO 63130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4841	Continued From page 20	A4841		

residents, the residents ' social well being, protective oversight of residents and upkeep of the facility. At a minimum, the staffing pattern for fire safety and care of residents shall be one (1) staff person for every fifteen (15) residents or major fraction of fifteen (15) during the day shift, one (1) person for every twenty (20) residents or major fraction of twenty (20) during the evening shift and one (1) person for every twenty-five (25) residents or major fraction of twenty-five (25) during the night shift. I/II

Time	Personnel	Residents
7 a.m. to 3 p.m. (Day)*	1	3-15
3 p.m. to 9 p.m. (Evening)*	1	3-20
9 p.m. to 7 a.m. (Night)*	1	3-25

*If the shift hours vary from those indicated, the hours of the shifts shall show on the work schedules of the facility and shall not be less than six (6) hours. III

This regulation is not met as evidenced by:
Class II

Based on interview and record review, the facility staff failed to notify a Nurse for an assessment after a resident fell. The staff transferred the resident off the floor without an assessment by a qualified person, for two of six sampled residents (Residents #3 and #1). The census was 59.

1. Review of Resident #3's medical record, showed the facility admitted the resident on 7/14/21, with diagnoses which included dementia with behavioral disturbance, chronic migraine, asthma, insomnia and anxiety.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32203	A. BUILDING: _____ B. WING _____	C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSLAND WALK SENIOR LIVING	868 KINGSLAND AVE SAINT LOUIS, MO 63130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4841	Continued From page 21 Review of the resident's progress notes dated 1/5/26 at 9:30 P.M., showed staff found the resident on the floor beside his/her bed. When asked what happened, the resident said he/she sat down on the floor. Vitals were done. Range of motion was performed; there was no sign of pain or bruising. The resident was assisted back to bed. During an interview on 4/22/26 at 11:48 A.M., Level One Medication Aide (LIMA) G said he/she assessed the resident by completing range of motion and collecting the resident's vitals. The LIMA said after he/she assessed the resident, he/she and another staff member assisted the resident back to bed. The LIMA said after the two staff members got the resident in bed; he/she called the Director of Nursing (DON) to let her know the resident fell. The LIMA said it was confirmed the resident fell after he/she called the resident's family member who viewed the camera footage in the resident's room, which showed the resident fell. The LIMA said he/she was told he/she could get residents off the floor if the resident did not have any injuries. He/she did not know a resident required a Nurse's assessment prior to lifting them off the floor. 2. Review of Resident #1's medical record, showed the facility admitted the resident on 6/21/23, with diagnoses which included Alzheimer's, dementia with behavioral disturbance, high blood pressure and kidney disease. Review of the resident's progress notes dated 3/17/26 at 1:15 A.M., showed staff found the resident on the side of his/her bed in a fetal position. Staff asked what happened and the	A4841		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32203	A. BUILDING: _____ B. WING _____	C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSLAND WALK SENIOR LIVING	868 KINGSLAND AVE SAINT LOUIS, MO 63130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4841	Continued From page 22 resident said he/she was looking for his/her insurance man and fell out of bed. Staff asked the resident if they were okay and if the resident had hit his/her head. The resident said no and staff noted no obvious signs of pain or bruising. The staff did a range of motion test and then helped the resident off the floor back into bed. The note also included the DON was notified. During an interview on 4/22/26 at 12:38 P.M., LIMA G said he/she did notify the DON but he/she could not remember if it was verbally or by phone. LIMA G said he/she checked his/her phone and did not show a call so he/she must have said something to the DON at some point. LIMA G said he/she thought a LIMA was able to do an assessment for the resident for range of motion and pain but was later informed only a nurse was able to conduct an assessment. LIMA G said another employee told him/her he/she could assess a resident. 3. During an interview on 4/22/26 at 2:41 P.M., the DON said she was not notified of any fall for the resident. The DON then produced her phone which showed no call or text message was received during the time period of the fall. The DON said staff had received training at the end of March related to assessments and falls. Until being advised of this issue the DON had believed all instances of LIMAs assessing residents had been addressed. The DON said all residents required a Nurse's assessment prior to lifting them off the floor. She said LIMAs are not qualified to assess residents.	A4841		
A7002	19 CSR 30-87.030(2) Wash Hands/Arms & Clean Fingernails	A7002		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32203	A. BUILDING: _____ B. WING _____	C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSLAND WALK SENIOR LIVING	868 KINGSLAND AVE SAINT LOUIS, MO 63130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A7002	Continued From page 23 Employees shall thoroughly wash their hands and the exposed portions of their arms with soap and warm water before starting work, during work as often as is necessary to keep them clean and after smoking, eating, drinking or using the toilet. Employees shall keep their fingernails clean and trimmed. II/III This regulation is not met as evidenced by: Class II* Based on observation and interview, the facility failed to ensure all staff washed their hands and/or replaced their gloves when serving the breakfast meal which consisted of French toast, eggs, sausage, bacon, potatoes and oatmeal. The census was 59. Observation on 4/22/26 between 8:23 A.M. and 9:11 A.M., of the breakfast meal service, showed the following: -At 8:23 A.M., the Director of Dining Services (DDS) applied clean gloves and then opened the stainless steel refrigerator and retrieved a slice of ham, touched the fryer basket handle and then grabbed a sausage patty with the same gloved hand; -At 8:24 A.M., the DDS chopped the sausage patty and a slice of ham into pieces. The DDS scraped the meats into his gloved hand and placed it on the flat top; -At 8:25 A.M., the DDS chopped an onion into pieces and scraped the onion into his hand and placed it on the flat top; -At 8:25 A.M., with the same gloved hands, the DDS rearranged menu tickets and dished up oatmeal. Without washing hands or changing his gloves, the DDS grabbed three pieces of bacon and chopped them into pieces. The DDS scraped the bacon into his gloved hands and placed it on	A7002		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32203	A. BUILDING: _____ B. WING _____	C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSLAND WALK SENIOR LIVING	868 KINGSLAND AVE SAINT LOUIS, MO 63130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A7002	Continued From page 24	A7002		

the flat top;
-At 8:26 A.M., with the same gloved hands, the DDS grabbed the butter brush and brushed butter over the flat top and then pushed a black rolling cart into the cook area. With the same gloved hands, the DDS grabbed biscuits from a cookie sheet and placed them in a stainless steel container and then put the container on the black rolling cart and pushed the black rolling cart back to the door;
-At 8:27 A.M., with the same gloved hands, the DDS poured liquid eggs onto the flat top, grabbed a spatula and flipped a pancake as well as spread out the liquid eggs. He then opened the stainless steel preparation station which contained various refrigerated food items and grabbed a handful of shredded cheese. He placed the shredded cheese inside the eggs;
-At 8:28 A.M., with the same gloved hands, the DDS grabbed three slices of bacon and placed it on a plate;
-At 8:29 A.M., with the same gloved hands, the DDS opened the stainless steel refrigerator and got three eggs out. He cracked all three eggs onto the flat top;
-At 8:30 A.M., with the same gloved hands, the DDS picked up a thermometer off the floor that fell. The DDS grabbed a handful of potato wedges from a cardboard box and put them in the fryer with the same hand he used to pick up the thermometer off the floor;
-At 8:31 A.M., with the same gloved hands, the DDS poured pancake mix onto the flat top and grabbed the spatula to retrieve the three fried eggs off the flat top. He put the eggs on a plate and then grabbed the butter brush and brushed butter over the flat top. The DDS retrieved one egg from the stainless steel refrigerator and cracked it onto the flat top. He then poured an egg onto the flat top and spread it out with a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32203	A. BUILDING: _____ B. WING _____	C 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSLAND WALK SENIOR LIVING	868 KINGSLAND AVE SAINT LOUIS, MO 63130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A7002	Continued From page 25 spatula. Without changing his gloves, he grabbed a sausage patty and put it on a plate. He also grabbed a handful of cheese from the preparation counter refrigerator and put it in the middle of the egg on the flat top. The DDS grabbed a potato wedge from the fry basket and put it on the plate; -At 8:34 A.M., without changing his gloves, the DDS rearranged the menu tickets again and then grabbed the butter brush and brushed butter onto the flat top. The DDS cracked two eggs on the flat top and touched the fryer basket handle to shake the potato wedges. The DDS chopped a slice of ham and a piece of bacon, then scraped the meats into his hand and placed it on the flat top; -At 8:36 A.M., the DDS grabbed the spatula and flipped the pieces of chopped meat and the fried egg. He placed the fried egg and meats onto a plate. Without changing his gloves, he grabbed a potato wedge and placed it on the plate; -At 8:37 A.M., the DDS poured egg batter onto the flattop and without changing his gloves, retrieved shredded cheese from the preparation counter. The DDS sprinkled the shredded cheese over the egg on the flat top; -At 8:40 A.M., without changing his gloves, the DDS grabbed a plate and picked up two biscuits from the cookie sheet in the oven and broke them in half. The DDS then grabbed two sausage patties and chopped them up. He scraped the patties into his gloved hand and put them in a gravy mixture on the stove. He then poured the gravy mixture over the biscuits; -At 8:42 A.M., without changing gloves, the DDS poured an egg on the flat top. He stirred the egg until it was cooked, cut it in half and put each half on a plate. He then grabbed, with his gloved hand, two pieces of bacon and two sausage patties and placed one of each onto the plate with the eggs;	A7002		

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A7002	Continued From page 26 -At 8:45 A.M., without changing gloves, the DDS grabbed a piece of bread and put it in a French toast mixture and placed the bread onto the flat top. He then cracked two eggs onto the flat top; -At 8:47 A.M., without changing gloves, the DDS used a spatula to remove the eggs from the flat top and placed them on a plate. With the same hand, he grabbed three pieces of bacon and placed them on the plate; -At 8:50 A.M., the DDS walked to the handwashing sink in the back of the kitchen and grabbed a brown paper towel. He used the brown paper towel to wipe his head and back of neck and threw the paper towel in the trash can; -At 8:51 A.M., without changing his gloves, the DDS walked back towards the flat top, opened the stainless steel refrigerator and grabbed one egg. He cracked the egg on the flat top and then grabbed a sausage patty and chopped it up. He scraped the chopped patty into his gloved hand and placed it in a Styrofoam container; -At 8:52 A.M., without changing his gloves, the DDS poured egg batter onto the flat top and grabbed shredded cheese from the preparation counter and sprinkled the cheese into the egg batter on the flat top. He grabbed a potato wedge and placed it in the Styrofoam container and then grabbed two pieces of bacon and placed them in a different Styrofoam container; -At 8:54 A.M., without changing his gloves, the DDS grabbed a piece of French toast from the flap top with the spatula and placed it on a place. With the same gloved hand, he reached into the powdered sugar bag with his whole hand and got a handful of powdered sugar which he sprinkled over the French toast; -At 9:00 A.M., the DDS took his gloves off and washed his hands for the first time in the breakfast service. After washing his hands, he turned the sink off with his bare hand and then	A7002		

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A7002	Continued From page 27	A7002		

put on a new set of gloves;
-At 9:04 A.M., the DDS walked into the walk-in refrigerator and retrieved bananas and oranges. He then left the kitchen with the fruit and placed them on a table in the dining room. He returned to the kitchen, grabbed the butter brush and brushed butter over the flat top;
-At 9:07 A.M., without changing his gloves, the DDS put two pieces of bread into the French toast mixture and then onto the flat top;
-At 9:09 A.M., the DDS rinsed his gloved hands off without soap in the hand washing sink and returned to the flat top. He poured eggs on the flat top, grabbed a spatula and spread the eggs out. After scraping the spatula off on the side of the flat top, he used it to flip the French toast. He put the French toast on a plate and then grabbed two pieces of bacon with his gloved hand. He sprinkled powdered sugar over the French toast and then walked towards the fryer and with the same gloved had that still had powdered sugar residue, he grabbed a potato wedge and placed it on the plate. A server came into the kitchen and told the DDS the resident said there was not enough powdered sugar on the French toast;
-At 9:11 A.M., without changing his gloves, the DDS sprinkled more powdered sugar over the French toast and handed it back to the server.

During an interview on 4/22/26 at 1:45 P.M., the DDS said he should have changed his gloves or washed his hands more often than what he did during the morning meal. He said he should have used tongs each time he touched something with his gloved hands. He said he did not realize he touched so many things without changing his gloves or washing his hands.

During an interview on 4/22/26 at 2:00 P.M., the Administrator said the DDS should have changed

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	32203	A. BUILDING: _____ B. WING _____	C 04/22/2026

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A7002	Continued From page 28 his gloves multiple times or washed his hands multiple times during the meal service. She said it was not acceptable to touch food with the same hands used to touch other surfaces in the kitchen. *The higher classification merited due to the extent of the violation.	A7002		
A7015	19 CSR 30-87.030(13) Food-Protected, Temp, Need to Contact DHSS At all times, including while being stored, prepared, displayed, served or transported to or from the facility, food shall be protected from potential contamination, including dust, insects, rodents, unclean equipment and utensils, unnecessary handling, coughs and sneezes, flooding, drainage and overhead leakage or overhead drippage from condensation. The temperature of potentially hazardous food shall be forty-five degrees Fahrenheit (45°F) or below or one hundred forty degrees Fahrenheit (140°F) or above at all times, except as otherwise provided in this section. In the event of a fire, flood, power outage or similar event that might result in the contamination of food, or that might prevent potentially hazardous food from being held at required temperatures, the person in charge shall immediately contact the Department of Health and Senior Services (the department). Upon receiving notice of this occurrence, the department shall take whatever action that it deems necessary to protect the residents. II/III This regulation is not met as evidenced by: Class II* Based on observation and interview, the facility	A7015		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A7015	Continued From page 29 failed to ensure stored food was maintained free from potential contamination when multiple boxes of food were observed open and exposed to potential contamination and when a knife was cleaned with the same rag used to clean the counter. The knife was then used to cut food which was served to a resident. The census was 59. 1. Observation on 4/22/26 between 8:47 A.M. and 9:11 A.M., showed the following: -At 8:47 A.M., the Director of Dining Services (DDS) grabbed a used rag from the left side of the preparation counter and wiped the counter and the knife down with the rag; -At 8:48 A.M., the DDS made fresh soapy water with a splash of bleach and carried the clear bucket over to the preparation counter; -At 8:50 A.M., the DDS grabbed a sausage patty and with the same knife, chopped the patty up into pieces and scraped the patty into his hand and carried it to a Styrofoam container where he placed the patty inside; -At 8:52 A.M., the DDS used the same knife to cut a piece of French toast in half; -At 8:54 A.M., the DDS sprinkled powdered sugar over French toast creating an area on the counter which was covered in powdered sugar; -At 8:55 A.M., the DDS grabbed the same rag and soaked it in the soapy water, rang it out, and then wiped the area of powdered sugar and the rest of the preparation counter and the knife with the rag; -At 9:11 A.M., the DDS grabbed the same knife and used it to cut more French toast in half. 2. Observation on 4/22/26 between 7:48 A.M. and 12:00 P.M., of the walk-in freezer in the back of the kitchen, showed the following: -On the bottom right side of the freezer, a	A7015		

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	32203	A. BUILDING: _____ B. WING _____	C 04/22/2026

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A7015	Continued From page 30 cardboard box of breaded unknown fish which was opened and exposed to air and contamination; -On the top right side of the freezer, a cardboard box of breaded cod which was opened and exposed to air and contamination. 3. Observation on 4/22/26 between 7:54 A.M. and 12:00 P.M., of the stainless steel refrigerator on the right side of the stove, showed a cookie sheet of bacon on the bottom shelf, which was opened and exposed to air and contamination. 4. During an interview on 4/22/26 at 1:45 P.M., the DDS said he should not have used the knife after wiping it with the rag. He said he should have gotten a new knife or a new rag before he wiped the knife and did not think of this at the time. He said all food should be covered and dated. He said he did not know there were open containers of food. 5. During an interview on 4/22/26 at 2:00 P.M., the Administrator said the DDS should not have used the same knife he wiped with the rag. She said he should have gotten a new knife. She said all of the food should have been covered and dated at all times to prevent contamination. *The higher the classification merited due to the extent of the violation.	A7015		
A7067	19 CSR 30-87.030(65) Nonfood Contact Surfaces,Cleaned as Needed Nonfood-contact surfaces of equipment shall be cleaned as often as is necessary to keep the equipment free of accumulation of dust, dirt, food particles and other debris. III	A7067		

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A7067	Continued From page 31 This regulation is not met as evidenced by: Based on observation and interview, the facility failed to ensure all non-food contact surfaces were clean when several appliances were observed with a build-up of grease and debris. The census was 59. 1. Observation on 4/22/26 between 7:46 A.M. and 2:00 P.M., of the microwave in the kitchen, showed the following: -The inside of the microwave was covered with food debris; -The door on the inside was covered in a brown, greasy substance; -The handle of the microwave door was greasy to the touch. 2. Observation on 4/22/26 between 7:47 A.M. and 2:00 P.M., of the flat top in the kitchen, showed the bottom left side, closest to the fryer covered in a tan, greasy like substance. 3. Observation on 4/22/26 between 7:47 A.M. and 2:00 P.M., of the fryer in the kitchen, showed all sides of the fryer were covered in a cream colored greasy like substance which streaked down all sides. 4. Observation on 4/22/26 between 7:47 A.M. and 2:00 P.M., of the char grill, showed the top right side of the char grill covered in a black, thick crust like substance. 5. Observation on 4/22/26 between 7:45 A.M. and 2:00 P.M., of the stainless steel wall behind the fryer and oven in the kitchen, showed the wall covered from top to bottom with white streaks which extended down the entire wall.	A7067		

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	32203	A. BUILDING: _____ B. WING _____	C 04/22/2026

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A7067	Continued From page 32 6. Observation on 4/22/26 between 7:47 A.M. and 2:00 P.M., of the dry storage pantry, showed the door handle of the dry pantry sticky to touch. 7. Observation on 4/22/26 between 7:47 A.M. and 2:00 P.M., of the dishwasher, showed the top was covered in tan crumbs. 8. Observation on 4/22/26 between 7:48 A.M. and 2:00 P.M., of the stainless steel refrigerators, showed the following: -The stainless steel refrigerator located on the right side of the steam table, the door handle covered in a clear, greasy like substance; -The stainless steel refrigerator located on the left side of the steam table, the door handle covered in a clear, greasy like substance; -The stainless steel cold food storage, attached to the steam table, the handle covered in a clear, greasy like substance. 9. During an interview on 4/22/26 at 1:45 P.M., the Director of Dining Services (DDS) said he would delegate the cleaning schedule to the employees but was responsible for all employees in the kitchen. He said he did not have a cleaning schedule yet and needed time to sit down and make sure it was thorough. He said he was having a difficult time getting the evening employees to clean the kitchen resulting in the morning shift having to clean up before they start their day. He said the stainless steel wall behind the appliances was cleaned quarterly by a company but did not know when the last time the company came. He said the kitchen appliances should be cleaned regularly to prevent build up. 10. During an interview on 4/22/26 at 2:00 P.M., the Administrator said the kitchen had a cleaning schedule but knew the schedule was not being	A7067		

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	32203	A. BUILDING: _____ B. WING _____	C 04/22/2026

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A7067	Continued From page 33 followed because the DDS informed her of the night shift not following the cleaning schedule. She said the kitchen should be cleaned as needed.	A7067		
A9107	19 CSR 30-91.010 (8)(B) Notice-posting resident room sign (8) If a resident installs and uses an electronic monitoring device, a notice to alert and inform visitors shall be posted at the entrance of the facility and resident's room. (B) The facility shall require the resident to post and maintain a conspicuous notice at the entrance of the resident's room stating: "This room is being monitored by an electronic monitoring device." III This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to post, outside resident rooms, a notice to alert and inform visitors electronic monitoring devices were in use in a resident's room, for two of three residents with an electronic monitoring device. The census was 59. 1. Observation on 4/22/26 between 7:54 A.M. and 2:45 P.M., of resident room 201, showed a camera mounted on the wall to the left of the door, facing the bed. There was no sign on the resident's door indicating the resident had a camera in his/her apartment. 2. Observation on 4/22/26 between 7:56 A.M. and 2:45 P.M., of resident room 203, showed a camera mounted on the wall to the left of the door, facing the bed. There was no sign on the resident's door indicating the resident had a camera in his/her apartment.	A9107		

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A9107	Continued From page 34 3. During an interview on 4/22/26 at 2:10 P.M., the Administrator said she did not know residents did not have signs on the outside of the doors indicating there was a camera in use.	A9107		
A9108	19 CSR 30-91.010 (9)(A)-(E) Installation-placement of EMD (9) The facility shall require an electronic monitoring device to be installed as follows: (A) In plain view; (B) Mounted in a fixed, stationary position; (C) Directed only on the resident who initiated the installation and use of AEM device; (D) Placed for maximum protection of the privacy and dignity of the resident and the roommate; and (E) In a manner that is safe for residents, employees, or visitors who may be moving about the room. II/III This STANDARD is not met as evidenced by: Class II* Based on observation and interview, the facility failed to ensure electronic monitoring devices were directed only on the resident who initiated the installation and use of the device, for one of three residents who had a camera. The census was 59. Observation on 4/22/26 between 7:54 A.M. and 2:45 P.M., of resident room #201, showed a camera mounted outside of the resident room, above the doorway, facing down towards the hall. The camera was plugged into an outlet on the wall outside of the room. The camera allowed for viewing of any resident who entered the room or	A9108		

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A9108	Continued From page 35 walked near the camera, when walking down the hall. During an interview on 4/22/26 at 2:10 P.M., the Administrator said she was not aware the camera was mounted outside the resident room and facing towards the hallway. *The higher classification merited due to the extent of the violation.	A9108		

PLAN OF CORRECTION

Provider/Supplier Name:	Kingsland Walk Senior Living
Street Address, City, Zip:	868 Kingsland Avenue University City, MO 63130

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	32203

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	This plan of correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute an admission on the part of the community as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of the Plan of Correction also does not constitute an admission that the findings constitute a deficiency cited are correctly applied	
	A4724 19 CSR 30-86.047(19) TB Screen Residents & Staff Kingsland Walk shall screen residents and staff for tuberculosis as required for assisted living/long term care facilities..	6/15/26
	Staff, prior to the initial start date, shall have the first of the two-step TB/PPD complete and documented prior to their first day of work. The second step shall be administered and documented within one to three weeks from their hire date. Staff shall have an annual TB test based on their anniversary date. A positive finding shall require a chest x-ray to rule out active pulmonary disease. Staff with a positive finding shall have a documented annual evaluation to rule out signs or symptoms of TB. A review shall be completed by a member of the Quality Team and results presented at the monthly Quality Team Meeting.	6/15/26 6/15/26
	The Director of Wellness or Designee, shall be responsible for ensuring compliance.	6/15/26

	A4755 19CSR 30-86.047(28)(H) Kingsland Walk shall admit or retain an individual for residency only if the individual does not require hospitalization or skilled nursing placement only if the Director of Wellness reviews the ISP with the resident, or legal representative of the resident at least annually or when there is a significant change in the resident's condition which may require a change in services.	6/15/26
	Resident #3 Individualized Service Plan shall be updated to address falls and new interventions to prevent future falls and shall address the resident's aggressive behaviors towards other residents and staff and shall include interventions. The ISP shall address the assistance needed with ADL's including the assistance needed when dressing.	6/15/26
	Resident #4 has been discharged from the community.	5/15/26
	Resident #1 Individualized Service Plan shall be updated to include assistance needed with ADL's including transfer to/from bed. Resident ISP shall include interventions from falls or other occurrences that may require intervention(s).	6/15/26
	Staff shall be in-serviced on notifying the Director of Wellness of any occurrence involving resident fall, resident to resident altercation and resident to staff altercation.	6/15/26
	Resident #6 Individualized Service Plan shall be updated to include interventions to address falls and prevention of falls.	6/15/26
	The Director of Wellness, or Designee shall be responsible for the development and maintenance of the resident ISP which shall outline the resident's needs, preferences, services to be provided, and goals. The Director of Wellness shall also be responsible for updating the ISP following any resident fall or other occurrence that may require intervention(s) and future prevention.	6/15/26

	The Quality Team shall provide a monthly compliance review to ensure resident ISP is updated and new intervention in place following any resident fall or occurrence that may require intervention(s). The Director of Wellness shall be responsible for ensuring compliance.	6/15/26 6/15/26
	A4797 19CSR 30-86.047(46) Kingsland Walk shall develop and implement a safe and effective system of medication control and use, which assures that all residents medications are administered by personnel at least eighteen years of age, in accordance with physicians instructions using acceptable nursing techniques. Kingsland Walk shall employ a licensed nurse eight (8) hours per week for every 30 residents to monitor each resident's condition and medication. Administration of medication shall mean delivering to a resident his or her prescription medication either in the original pharmacy container, or for internal medication, removing an individual dose from the pharmacy container and placing it in a small cup container or liquid medium for the resident to remove from the container and self-administer. External prescription medication may be applied by facility personnel if the resident is unable to do so and the resident's physician so authorizes. All individuals who administer medication shall be trained in medication administration and, if not a physician or a licensed nurse, shall be a certified medication technician or level 1 medication aide. Kingsland Walk shall provide a system to ensure staff maintain an appropriate certification to administer medications to residents. The payroll software implemented 4/21/26 shall be updated to include licensure and certification renewal dates for all licensed nurse, certified medication aide and level 1 medication aides. Compliance shall be monitored by Human Resources.	6/15/26 6/15/26 6/15/26

	The Quality Team shall provide a monthly compliance review to ensure all licensure and certification renewals are updated and in compliance. The Executive Director or Designee shall be responsible to ensure compliance.	6/15/26 6/15/26
	A4798 19 CSR 30-86.047(47)(A) Kingsland Walk shall ensure that no medication, treatment or diet shall be administered without an order from an individual lawfully authorized to prescribe such and the order shall be followed. Resident #4 has been discharged from Kingsland Walk. The Director of Wellness shall ensure that no medication, treatment or diet shall be administered without an order from an individual lawfully authorized to prescribe such and that orders are followed. The Quality Team shall provide a monthly compliance review to ensure medications, treatments or diets are administered per physician orders. The Director of Wellness shall be responsible to ensure compliance.	6/15/26 6/15/26 6/15/26 6/15/26 6/15/26
	A4841 19 CSR 30-86.047(61)(A) Kingsland Walk shall have an adequate number and type of personnel for the proper care of residents, residents' social well-being, protective oversight of residents and upkeep of the facility. Resident #3, Resident #1 . Staff shall be in-serviced on Fall policy which includes notification to the Director of Wellness. Staff shall also be in-serviced on proper protocol on the process following an occurrence such as a fall. The Director of Wellness or Designee shall ensure that all incidents including falls shall be reviewed and investigated. The Director of Wellness or Designee shall	6/15/26 6/15/26 6/15/26

	be responsible for updating the resident ISP to include interventions and future prevention. The Quality Team shall provide a monthly compliance review of all incidents, including falls to ensure proper protocol was followed and the ISP updated with interventions and future prevention. The Director of Wellness shall be responsible for ensuring compliance.	6/15/26 6/15/26
	A7002 19 CSR 30-87.030(2) Kingsland Walk shall ensure all employees thoroughly wash their hands and the exposed portions of their arms with soap and warm water before starting work, during work, and as often as necessary to keep them clean. This shall include after smoking, eating, drinking or using the toilet. Staff shall keep fingernails clean and trimmed. The Executive Director or Designee shall in-service all culinary service employees on proper hand washing, glove use and cross contamination The Quality Team shall provide a monthly compliance review which will include observation of food preparation, hand washing, glove use and potential for cross contamination. Observation shall also include proper use of hair nets. The Director of Dietary Service shall be responsible for ensuring compliance with infection control procedures.	6/15/26 6/15/26 6/15/26 6/15/26
	A7015 19 CSR 30-87.030(13) Kingsland Walk shall ensure that, at all times while being stored, served or transported that food is protected from potential contamination including dust, insects, rodents, unclean equipment and utensils, unnecessary handling, coughs and sneezes, flooding, drainage and overhead leakage or overhead drippage from condensation.	6/15/26

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	The Executive Director shall in-service all culinary staff on the proper storage, handling, and transportation of food. In-service topics will include cross contamination	6/15/26
	The Quality Team shall provide a monthly compliance review which will include observation of food storage, handling and transportation.	6/15/26
	The Director of Dietary Service shall be responsible for ensuring compliance with proper storage, handling and transport of food.	6/15/26
	A7067 19CSR 30-87.030(65) Kingsland Walk shall ensure that non-contact food surfaces of equipment are cleaned as often as necessary to keep equipment free of accumulation of dust, dirt, food particles and other debris.	6/15/26
	The Director of Dietary Services shall ensure that all equipment surfaces, walls, sides of equipment are thoroughly cleaned. The Director of Dietary Services shall ensure that a cleaning schedule is in place and ensure compliance with completion.	6/15/26
	The Quality Team shall provide a monthly compliance review which shall include inspection of all equipment surfaces, walls, sides of equipment are free of accumulation of dust, dirt, food particles and other debris.	6/15/26
	The Director of Dietary Services shall be responsible for ensuring compliance.	6/15/26
	A9107 10 CSR 30-91.010(8)(B) Kingsland Walk shall ensure that if a resident installs and uses an electronic monitoring device, a notice to alert and inform visitors shall be posted at the entrance of the facility and residents room. Kingsland Walk shall require the resident or designee to post and maintain a conspicuous notice at the entrance of the residents room stating the room is being monitored by an electronic monitoring device.	6/15/26
	A notice to alert and inform visitors of the use of an electronic monitoring device shall be posted at the entrance of the facility and outside of resident rooms #201 and #203. A notice shall be posted at the entrance of resident	6/15/26

	rooms #201 and #203 stating the room is being monitored by an electronic monitoring device. The Quality Team shall provide a monthly compliance review which shall include the proper posting of notice at facility entrance and outside resident rooms. The Executive Director shall be responsible for ensuring compliance.	6/15/26 6/15/26
	A9108 19 CSR 30-91.010(9)(A-E) Kingsland Walk shall require an electronic monitoring device to be installed in compliance with regulatory requirements and shall ensure the device is in plain view, mounted in a fixed, stationary position, directed only on the resident who initiated the installation of the EMD, placed for maximum protection of privacy and dignity of resident and roommate if applicable, and in a manner that is safe for residents, employees, or visitors who may be moving about the room. The EMD mounted above resident room #201 has been removed. The Quality Team shall provide a monthly compliance review which shall include monitoring for any EMD placed outside of any resident room. The Executive Director shall be responsible for ensuring compliance.	6/15/26 6/15/26 6/15/26 6/15/26

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

STATE PLAN OF CORRECTION

Agency Name	Kingsland Walk Senior Living
STREET ADDRESS, CITY, ZIP:	868 Kingsland Avenue, University City, MO 63030
Provider Number	32203
Exit Date	04/22/2026

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERRENCED TO THE APPROPRIATE DEFICIENCY)

Tag Number	The Administrator signing and dating the first page of the STATE FORM is indicating their approval of the plan of correction being submitted on this form.	(X5) COMPLETION DATE
A4837	Kingsland Walk Senior Living will ensure Resident #4's unwitnessed fall is documented in the resident's record with appropriate interventions. The Director of Health and Wellness will audit all current resident records and incident reports for the previous 30 days to ensure all accidents and incidents are documented in the resident's clinical record. All direct-care staff will be re-educated on the requirement to promptly report and document all resident accidents, incidents, and falls in the resident's clinical record. The Director of Health and Wellness will review all accident and incident reports weekly for four weeks to ensure documentation is completed in the resident's record. Any identified concerns will be addressed immediately. Audit results will be reported to Quality Review Team as needed for further recommendations. The Director of Health and Wellness will be responsible for maintaining compliance.	06/15/2026