STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B023018	A. BUILDING: _____ B. WING _____	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STAR LIVING, LLC	3911 W 13TH STREET LAWRENCE, KS 66049

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S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey for the above named facility conducted on 03/31/26 and 04/01/26.	S 000		
S5185 SS=F	26-42-206 (a) (b) (c) Dietary Services (a) The administrator or operator of each home plus shall ensure the provision or coordination of dietary services to residents as identified in each resident ' s negotiated service agreement. (b) The supervisory responsibility for dietetic services shall be assigned to one employee. (c) If a resident ' s negotiated service agreement includes the provision of a therapeutic diet, mechanically altered diet, or thickened consistency of liquids, a medical care provider ' s order shall be on file in the resident ' s clinical record, and the diet or liquids, or both, shall be prepared according to instructions from a medical care provider or licensed dietitian. This REQUIREMENT is not met as evidenced by: K.A.R. 26-42-206 (b) The facility reported a census of 12 residents. The sample included 2 "Residents'" (R)'s. Based on record review and interview the Operator failed to ensure the supervisory responsibility for dietetic services was assigned to one employee. Findings included:	S5185		

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

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S5185	Continued From page 1 - Interview on 04/01/26 at approximately 03:30 PM with Operator A and Licensed Nurse B confirmed the facility did not employee a dietetic supervisor as defined in K.A.R. 26-39-100 (4) (w) "Dietetic services supervisor means an individual who meets one of the following requirements: (1) is licensed in the state as a dietitian; (2) has an associate's degree in dietetic technology from a program approved by the American dietetic association; 93) is a dietary manager who is certified by the certifying board for dietary managers of the association of nutrition and foodservice professionals; or (4) has training and experience in dietetic services supervision and management that are determined by the state department for gaining and disability services to be equivalent in content to the requirement specified in paragraph (2) or (3). The Operator failed to ensure the supervisory responsibility for dietetic services was assigned to one employee.	S5185		
S5300 SS=D	26-42-205 (d) (1-2) Facility Administration of Medications (d) Home administration of resident ' s medications. If a home is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for	S5300		

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S5300	Continued From page 2 which the home has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: K.A.R. 26-42-205 (d) The facility reported a census of 12 residents. The sample included 2 "Residents'" (R)'s. Based on record review and interview the Operator failed to ensure that all medications managed by the home were administered to R2 in accordance with professional standards of practice. Findings included: - Record review for R2 revealed an admission date of 05/09/22 with diagnoses of dementia, multiple sclerosis, osteopenia, osteoarthritis of the lumbar spine, and Alzheimer's disease. Review of R2's FCS dated 01/16/26 revealed R2 was unable to perform bathing, dressing, toileting, transferring, walking/mobility, and eating. R2 lacked the ability to manage her own medications and medical treatments and was incontinent. R2 had impaired short-term memory, long-term memory, memory/recall, and decision making. R2 was rarely or never able to make herself understood and she rarely or never understood others. R2 was at risk for falls and impaired decision making.	S5300		

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S5300	Continued From page 3 Review of R2's NSA dated 01/16//26 in the section titled "Medications" identified qualified facility staff would administer and manage R2's medications. Review of R2's "Health Service Plan" (HSP) in the "Focus" section titled "Medication and Treatment Management", instructed facility "staff to provide all medications and treatment management per physician orders". Review of R2's home provided electronic "Medication Administration Record" (eMAR) dated 03/26 revealed and order for Lorazepam Intensol 2"milligrams" (mg) /"milliliter" (ml) administer 0.25ml every 4 hours as needed for anxiety and or restlessness. "Certified Medication Aide" (CMA) C documented that the Lorazepam Intensol 2mg/ml for anxiety was administered on 03/02/26, 03/12/26, 03/13/26, 03/15/26, 03/16/26, 03/17/26 and 03/18/26. CMA C continued to document the results were "effective." R2's facility provided "Nurse" notes lacked documentation of CMA C calling the nurse prior to the administration o the Lorazepam Intensol. Review of the "Certified Nurse Aide" Curriculum dated 05/10/13 page 167 revealed the following; "PRN-to be given whenever necessary ...Medication aides may not administer PRN medications which require an assessment. For example, a medication aide could not administer a PRN medication order for Ativan PRN for agitation. Standard of practice is for a nurse to assess the resident and decide the best method for reducing the resident's agitation. The	S5300		

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S5300	Continued From page 4 medication aide would need to call a nurse for instructions. Interview on 04/01/26 at approximately 03:30PM with Operator A and Licensed Nurse B confirmed R2's medical record lacked documentation of CMA C calling the nurse prior to the administration of the Lorazepam Intensol for anxiety and/or restlessness. The Operator failed to ensure that all medications managed by the home were administered to R2 in accordance with professional standards of practice.	S5300		
S5301 SS=D	26-42-205 (d) (3) Facility Administration of Medications (d) (3) A licensed nurse or medication aide shall perform the following: (A) Administer only the medication that the licensed nurse or medication aide has personally prepared; (B) identify the resident before medication is administered; (C) remain with the resident until the medication is ingested or applied; and (D) document the administration of each resident ' s medication in the resident ' s medication administration record immediately before or following completion of the task. If the medication administration record identifies only time intervals or events for the administration of medication, the licensed nurse or medication aide shall document the actual clock time the medication is administered. This REQUIREMENT is not met as evidenced	S5301		

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S5301	Continued From page 5 by: K.A.R. 26-42-205 (d) (3) (D) The facility reported a census of 12 residents. The sample included 2 "Residents'" (R)'s. Based on record review and interview the Operator failed to ensure the facilities "Licensed Nurses'" (LN)'s and "Certified Medication Aides'" (CMA)'s documented the administration of each resident's medication in the resident's medication administration record immediately before or following completion of the task for R1. Findings included: - Record review for R1 revealed an admission date of 08/24/20 with diagnoses of Alzheimer's disease with delusions, hypertension, type two diabetes mellitus, peripheral vascular disease, osteoarthritis, and bilateral hearing loss Review of R1's "Functional Capacity Screen" (FCS) dated 01/23/26 revealed R1 was unable to perform bathing and dressing. R1 required physical assistance with bathing and supervision with toileting, transferring, walking/mobility, and eating. R1 lacked the ability to manage his own medications and medical treatments, and he was incontinent. R1 had impaired short-term memory, memory/recall, and decision making. R1 was able to make himself understood and he usually understood others. R1 was at risk for falls, impaired vision, and impaired decision making. He used no mobility device. Review of R1's "Negotiated Service Agreement" (NSA) dated 01/23/26 in the section titled	S5301		

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S5301	Continued From page 6 "Medications" identified qualified facility staff would administer and manage R1's medications. Review of R1's "Health Service Plan" (HSP) in the "Focus" section titled "Medication and Treatment Management", instructed facility "staff to provide all medications and treatment management per physician orders". Review of R1's facility provided electronic "Medication Administration Record" (eMAR) dated 03/26 revealed the following: An order for Atorvastatin 10 "Milligrams" (mg) one tablet by mouth to be administered daily. R1's eMAR lacked documentation on 03/20 of R1's Atorvastatin being administered. An order for Cetirizine 10mg tablet by mouth to be administered every morning. R1's eMAR lacked documentation on 03/20 of R1's Cetirizine being administered. An order for Fluvoxamine 50mg tablets: one tablet daily for delusions. R1's eMAR lacked documentation on 03/28 and 03/30 of R1's Fluvoxamine being administered. An order for Lisinopril 10mgg tablet to by mouth to be administered every morning for hypertension: hold if the systolic blood pressure was less then 100. R1's eMAR lacked documentation on 03/20 of R1's blood pressure being obtained and the eMAR further lacked documentation of R1's Lisinopril being administered. An order for Metformin Extended Release 500mg	S5301		

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S5301	Continued From page 7	S5301		

on tablet by mouth twice daily. R1's eMAR lacked documentation on 03/20, 03/28, and 03/30, of R1's blood glucose being documented and the eMAR further lacked documentation of the Metformin Extended Release being administered.

An order for Mirtazapine 7.5mg one tablet by mouth daily for mood disorder. R1's eMAR lacked documentation on 03/28 and 03/30 of the Mirtazapine being administered.

An order for Rivastigmine: apply one patch daily and change once daily for Alzheimer's dementia. R1's eMAR lacked documentation on 03/20 of the Rivastigmine patch being applied and changed.

An order for Toujeo Solostar 300 units/Milliliter. Inject 6 units subcutaneously daily. R1's eMAR lacked documentation on 03/28 of the Toujeo Solostar 6 units being administered.

An order for Triamcinolone 0.1% cream: apply thin layer topically to affected area twice daily. R1's eMAR lacked documentation on 03/20, 03/28 and 03/30 of the Triamcinolone 0.1% cream being applied twice daily.

An order to Check Blood Glucose Daily. R1's eMAR lacked documentation of his blood glucose being checked on 03/20/26.

Interview on 04/01/26 at approximately 03:30PM with Operator A and Licensed Nurse B confirmed R1's eMAR lacked documentation of all ordered medications being administered.

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S5301	Continued From page 8 The Operator failed to ensure the facilities LN's and CMA's documented the administration of each resident's medication in the resident's medication administration record immediately before or following completion of the task for R1.	S5301		
S5335 SS=F	28-39-437 Construction (a) Each home-plus facility shall be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public. (b) All new construction, renovation, remodeling, and changes in building use in existing buildings shall comply with building and fire codes, ordinances, and regulations enforced by city, county, and state jurisdictions, including the state fire marshal. This REQUIREMENT is not met as evidenced by: K.A.R. 28-39-437 (a) The facility reported a census of 12 residents. The sample included 2 "Residents'" (R)'s. Based on observation and interview the Operator failed to ensure the home was maintained to protect the health and safety of the residents, personnel and public. Findings included: - Observation on 03/21/26 at approximately 08:45AM, the door to the home's laundry room was propped open with a doorstop, there was a keypad in place on the handle of the door. On the sink in the southeast corner of the laundry	S5335		

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S5335	Continued From page 9 room, sat in a clear plastic tub was a large container that lacked a label and was approximately 1/3 full of a bluish liquid. Under the sink in a cabinet the door freely opened and there was a large container that had hand written in black marker "Bleach", one large container that had hand written in black marker "Odoban", and a large container of laundry soap. Interview on 03/31/26 at approximately 08:50 AM with Operator A confirmed the liquid in the large container on the sink was laundry soap, and she further confirmed the door was to be closed and locked at all times. The Operator failed to ensure the home was maintained to protect the health and safety of the residents, personnel and public.	S5335		