STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N067001S	A. BUILDING: _____ B. WING _____	08/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES VIII	114 E MARSHALL ERIE, KS 66733

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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey at the above named residential health care facility conducted on 8-10-16, 8-11-16 and 8-15-16.	S 000		
S3081 SS=D	26-41-201 (c) Functional Capacity Screen Reassessment (c) Designated facility staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(c) The facility reported a census of 22 residents. The sample included 3 residents. Based on record review and interview for 1 of 3 sampled residents, the operator failed to ensure designated facility staff shall conduct a screening to determine each resident's functional capacity following any significant change in condition as defined in K.A.R. 26-39-100. Findings included: - Record review for resident #202 revealed admission on 5-5-14 with diagnoses Dementia, Hypertension, and Urge Incontinence.	S3081		

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

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S3081	Continued From page 1 The Functional Capacity Screen (FCS) dated 5-5-16 recorded resident required physical assistance with bathing, dressing and management of medications and treatments; independent with toileting, transfers , walking/mobility and eating. Cognition: problems with short term memory, long term memory, memory/recall and decision-making. Current problems/risks identified included impaired vision, impaired hearing and impaired decision-making. The FCS lacked revision following hospitalization with a significant change in condition. Resident now requires physical assistance with transfers and mobility (per wheelchair) at times; and supervision with toileting and eating. The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 5-5-16 recorded services for staff to provide physical assistance with bathing and dressing (noted that resident refuses care at times); staff to assess for weakness or unsteady gait (added 7-20-16) and store, set-up, administer and reorder medications. Also added 7-20-16: staff to monitor for increased confusion after hospitalization. Nursing Notes revealed the following: Resident admitted to hospital on 1-14-16 with diagnosis of pneumonia. Returned to facility on 1-18-16. Resident admitted to hospital on 7-17-16 with diagnosis left lower lobe pneumonia. Returned to facility on 7-20-16. 7-22-16 at 4:45 p.m.: "Resident has been in bed with eyes closed every time staff check on resident. Resident got up at 4:00 pm. and drank approximately 8-10 ounces of orange juice and a one small bite of applesauce. Resident refused	S3081		

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S3081	Continued From page 2	S3081		

to eat anything else. Refused alternatives." Signed by certified staff C.
7-23-16 at 2:30 p.m.: "Resident up to dining room for meals did not eat well..." Signed by certified staff B.
7-24-16 at 4:00 p.m.: "...Resident came to dining room for breakfast but had a very hard time walking and was bent over. Resident stated back hurts...ate fairly well for breakfast...CMA (certified medication aide) notified (family member). I described how he/she was walking and...I was concerned...notified nurse...(family member would like for (resident) to be in a wheelchair." Signed by certified staff B.
7-24-16 at 5:45 p.m.: "Resident to supper via wheelchair. Resident did not eat well...nurse notified...staff had to assist feeding him/her. Resident acted like he/she couldn't feed self." Signed by certified staff B.
7-28-16 at 1:00 p.m.: "Resident to lunch in wheelchair. Resident ate 50%, fed self." Signed by unknown certified staff.
7-26-16 at 10:05 a.m.: "Resident up to dining room for breakfast. resident drank 8 ounces of orange juice and approximately 4 ounces of water and took one bite of toast with bacon...this certified medication aide receive call from hospice at 9:00 a.m. stated their services would start on the 28th..." Signed by certified staff C.

Fax Communication Sheet dated 7-25-16 stated: "Resident is refusing most of medication, only eating one or two meals a day. Sleeping most of the day. Not up walking like he/she did when he/she was in the hospital...not sure if we give more time or start questioning need for hospice. Lungs sound diminished." Signed by licensed staff A.
Interview with certified staff C stated resident "on worse days shouldn't walk, won't pick up feet and

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S3081	Continued From page 3 drags feet on carpet...really wobbly, won't hold onto handrails. That's when we utilize the wheelchair. Happens almost daily but not all day. If restless during night, wakes with increased confusion and walking is worse." Further stated resident requires additional time in order to eat more. Drastic change since last bout of pneumonia. Interview on 8-11-16 at 11:40 a.m. with certified staff C stated resident "on worse days shouldn't walk, won't pick up feet and drags feet on carpet...really wobbly, won't hold onto handrails. That's when we utilize the wheelchair. Happens almost daily but not all day. If restless during night, wakes with increased confusion and walking is worse." Further stated resident requires additional time in order to eat more. Drastic change since last bout of pneumonia. Resident is "usually continent" but "he/she does wear depends and we check him/her every 2 hours." Interview on 8-10-16 at 3:27 p.m. with licensed staff A confirmed the resident required staff monitoring of eating ("we have to cue and coax her to eat") and incontinence ("staff checks every two hours"), physical assistance with transfers and use of wheelchair ("requires it at times with staff to push") when resident is weak. Licensed staff A confirmed the resident should have been reassessed upon return from hospital on 7-20-16 with a significant change in condition. For resident #202, the operator failed to ensure the licensed nurse conducted a screening to determine the resident's functional capacity following hospital return with a significant change in condition as evidenced by decreased ability to eat, transfer and ambulate.	S3081		

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S3085 SS=E	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(a) The facility reported a census of 22 residents. The sample included 3 residents. Based on observation, record review and interview for 3 (#201, #202, #203) of 3 sampled residents, the operator failed to ensure the negotiated service agreement shall provide a description of the services the resident will receive; identification of the provider of each service; and identification of each party responsible for payment if outside resources provide a service. Finding included:	S3085		

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S3085	Continued From page 5 - Record review for resident #201 revealed admission on 7-7-16 with diagnoses Dementia with Psychosis, Hyperlipidemia, Gastroesophageal Reflux Disease, and Depression/Anxiety. The Functional Capacity Screen dated 7-7-16 recorded resident required physical assistance with bathing and management of medications and treatments; supervision with walking/mobility and independent with dressing, toileting, transfers and eating. Continent of bladder. Cognition: problems with decision-making. Current problems/risks identified included impaired vision, impaired hearing and impaired decision-making. The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 7-7-16 recorded services for facility staff to provide assistance with bathing twice weekly; monitor resident's ambulation in common areas and store, set-up, administer and reorder medications. The NSA/HCSP lacked documentation of services for staff assistance with use of hearing aides; and selection and laying out of appropriate clothing prior to dressing. Nursing Notes recorded the following: 7-8-16 at 7:00 p.m.: "...Resident states he/she has hearing aides but cannot put them in...Resident can dress self but needs appropriate clothing laid out..." Signed by certified staff C. Interview on 8-11-16 at 11:30 with certified staff C stated resident needs appropriate clothing laid out "for time of day" then is able to dress self; requires physical assistance with placement, removal and changing batteries of hearing aides. Stated resident's hands are too shaky to	S3085		

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S3085	Continued From page 6 manipulate the hearing aides. Interview on 8-11-16 at 12:15 p.m. with licensed staff A confirmed the NSA/HCSP lacked instructions for staff to pay out appropriate clothing for resident and instructions for use and management of hearing aides. For resident #201, the operator failed to ensure the negotiated service agreement/health care service plan provided a description of services for dressing and use of hearing aides. - Record review for resident #202 revealed admission on 5-5-14 with diagnoses Dementia, Hypertension, and Urge Incontinence. The Functional Capacity Screen dated 5-5-16 recorded resident required physical assistance with bathing, dressing and management of medications and treatments; independent with toileting, transfers , walking/mobility and eating. Cognition: problems with short term memory, long term memory, memory/recall and decision-making. Current problems/risks identified included impaired vision, impaired hearing and impaired decision-making. The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 5-5-16 recorded services for staff to provide physical assistance with bathing and dressing (noted that resident refuses care at times); staff to assess for weakness or unsteady gait (added 7-20-16) and store, set-up, administer and reorder medications. Also added 7-20-16: staff to monitor for increased confusion after hospitalization.	S3085		

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S3085	Continued From page 7 The NSA/HCSP lacked documentation of hospice services including provider of service. Nursing Notes revealed the following: 7-26-16 at 10:05 a.m.: "Resident up to dining room for breakfast. resident drank 8 ounces of orange juice and approximately 4 ounces of water and took one bite of toast with bacon...this certified medication aide received call from hospice at 9:00 a.m. stated their services would start on the 28th..." Signed by certified staff C. Fax Communication Sheet dated 7-25-16 stated: "Resident is refusing most of medication, only eating one or two meals a day. Sleeping most of the day. Not up walking like he/she did when he/she was in the hospital...not sure if we give more time or start questioning need for hospice. Lungs sound diminished." Signed by licensed staff A. Nurse Practitioner replied with order for hospice services. Interview on 8-10-16 at 3:27 p.m. with operator and licensed staff A confirmed the NSA/HCSP lacked identification of hospice provider, description of hospice services being provided and each party responsible for payment of the hospice provider. For resident #202, the operator failed to ensure the negotiated service agreement provided identification of the hospice provider, a description of hospice services and identification of each party responsible for payment of the hospice provider. - Record review for resident #203 revealed admission on 12-1-15 with diagnoses Hypertension, Chronic Obstruction Pulmonary	S3085		

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S3085	Continued From page 8 Disease, Back Pain, Macular Degeneration, and Pulmonary Embolism. The Functional Capacity Screen dated 12-1-15 recorded resident required physical assistance with bathing, dressing, toileting, transfers, walking/mobility, eating and management of treatments; and unable to perform management of medications. Occasionally incontinent of bladder. Cognition: problems with short term memory and decision-making. Current problems/risks included impaired vision, impaired hearing and impaired decision-making. The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 12-1-15 recorded services for physical assistance with bathing (per hospice aide twice weekly); dressing (AM and PM); toileting, transfers, walking/mobility and eating. Nursing Notes revealed the following: 12-1-15 at 2:45 p.m.: "Resident has macular degeneration with severe impaired vision. He/She can only see shapes and some color..." Signed by licensed staff D. 12-2-15 at 1:00 p.m.: "...He/She is very hard of hearing and wears bilateral hearing aides. Staff to remove them at night and put back in every morning. Staff will also have to change hearing aide batteries as needed." Signed by licensed staff D. Interview on 8-11-16 at 12:35 p.m. with licensed staff A confirmed the NSA/HCSP lacked documentation of instructions to staff for management of hearing aides and interventions for severely impaired vision. For resident #203, the operator failed to ensure	S3085		

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S3085	Continued From page 9 the negotiated service agreement provided a description of services the resident would receive for management of hearing aides and impaired vision.	S3085		
S3200 SS=E	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility 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 which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d) The facility reported a census of 22 residents. The sample included 3 residents. Based on record review and interview for 3 (#201, #202, #203) of 3 sampled residents, the operator failed to ensure all medications and biologicals are administered to the residents in accordance with a medical care provider's written order and	S3200		

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S3200	Continued From page 10 professional standards of practice. Findings included: The facility policy for medication administration included the following procedures: The nurse will note all orders received from the physician and place on the Medication Administration Record (MAR). Prior to administration, the qualified staff will ensure the order matches the label. PRN medications will be administered as ordered. When a resident is unable to clearly state the reason for the medication and request it, but the staff notes indications or symptoms to indicate need the nurse will be notified for an onsite or phone assessment prior to giving the medication. The policy failed to follow standards of practice that certified staff can only admin PRN medications if the order includes the name, dosage and specific reason for administration. - Record review for resident #201 revealed admission on 7-7-16 with diagnoses Dementia with Psychosis, Hyperlipidemia, Gastroesophageal Reflux Disease, and Depression/Anxiety. The Functional Capacity Screen dated 7-7-16 recorded resident required physical assistance with management of medications and treatments. Cognition: problems with decision-making. The Negotiated Service Agreement/Health Care Service Plan dated 7-7-16 recorded services for facility staff to store, set-up, administer and reorder medications. Review of Medication Administration Record	S3200		

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S3200	Continued From page 11 (MAR) for August 2016 revealed the following: Probiotic take 1 tablet (tab) by mouth (po) daily for intestinal health. Hold 8-10-16 to 8-16-16 then resume. The medication lacked documentation of a physician's order. Review of Fax Communication Sheet signed by physician on 7-18-16 revealed the following orders: Tylenol 325 milligrams (mg) 2 tabs po every 6 hours as needed. Hydroxyzine 25 mg 1 tab po as needed for anxiety. Omperazole 40 mg 1 po every morning. Magnesium 400 mg 1 twice a day as needed. The orders for Tylenol and Magnesium lacked clarification of parameters for administration; the order for Hydroxyzine lacked clarification of how frequently the medication could be administered. The MAR lacked documentation of the above medications. Further review of MAR revealed resident receiving Tylenol with Codeine 300-60 mg (take one tab by mouth every 6 hours as needed for chronic pain). The MAR documented resident received the medication twice on 8-1-16, 8-2-16, 8-3-16, and 8-4-16; once on 8-6-16, 8-7-16, 8-8-16; and twice on 8-9-16; and once on 8-10-16. The MAR lacked documentation of instructions from a nurse to administer the medication. Interview on 8-11-16 at 11:30 a.m. with certified staff C stated if a resident requests a "PRN" medication he/she will look to see if it is within the time limit, get the medication, write on the PRN sheet and take it to the resident. Confirmed he/she does not call the nurse first. Stated only one resident receiving PRN medication that he/she would call the nurse first and ask for instruction to administer.	S3200		

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S3200	Continued From page 12 Interview on 8-10-16 at 12:30 p.m. with licensed staff A confirmed the above discrepancies between the physician's orders and Medication Administration Record. For resident #201, the operator failed to ensure the medications were administered to the resident in accordance with a medical care provider's written order and professional standards of practice. - Record review for resident #202 revealed admission on 5-5-14 with diagnoses Dementia, Hypertension, and Urge Incontinence. The Functional Capacity Screen dated 5-5-16 recorded resident required physical assistance for management of medications and treatments. Cognition: problems with short term memory, long term memory, memory/recall and decision-making. The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 5-5-16 recorded services for staff to store, set-up, administer and reorder medications. Review of Mediation Administration Record for August 2016 revealed: Tylenol 650 mg every 4-6 hours as needed. The medication was administered by certified staff B on 8-1-16. The MAR lacked documentation of an indication for when Tylenol should be administered and further lacked documentation of instructions from nurse to administer. Interview on 8-10-16 at 2:45 p.m. with certified staff B stated the Tylenol was given to resident for a complaint of "back pain". Stated "I usually just	S3200		

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S3200	Continued From page 13 give the PRN when they ask for it, there's just a couple of residents who we ask the nurse first...doesn't think there's anyone else we have to ask the nurse first" before administering PRN medication to. Interview on 8-10-16 at 2:45 p.m. with licensed staff A stated "they call me if it's a pain pill (narcotic) or Lorazepam". For resident #202, the operator failed to ensure all medications were administered according to professional standards of practice when certified staff administered PRN (as needed) medication without instructions from a licensed nurse. - Record review for resident #203 revealed admission on 12-1-15 with diagnoses Hypertension, Chronic Obstruction Pulmonary Disease, Back Pain, Macular Degeneration, and Pulmonary Embolism. The Functional Capacity Screen dated 12-1-15 recorded resident unable to perform management of medications and required physical assistance with treatments. The Negotiated Service Agreement/Health Care Service Plan dated 12-1-15 recorded services for facility staff to store, set-up, administer and reorder medications. Review of physician orders signed 12-3-15 revealed: Ipratropium Bromide HFA Inhaler 17 micrograms 1 inhalation twice a day. Lorazepam 0.5 mg 1 tablet every 12 hours. Review of the Medication Administration Record revealed it lacked documentation of the	S3200		

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	N067001S	A. BUILDING: _____ B. WING _____	08/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES VIII	114 E MARSHALL ERIE, KS 66733

(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
S3200	Continued From page 14 Ipratropium Bromide inhaler. The Lorazepam was documented as administered twice daily at 8 a.m. and 5 p.m. (9 hours apart) instead of 12 hours apart as ordered by physician. Interview on 8-11-16 at 12:25 p.m. with licensed staff A confirmed the above discrepancies between the physician's orders and the Medication Administration Record. For resident #203, the operator failed to ensure the medications were administered to the resident in accordance with a medical care provider's written order and professional standards of practice.	S3200		
S3216 SS=E	26-41-205 (i) Disposition of Medication (i) Accountability and disposition of medications. Licensed nurses and medication aides shall maintain records of the receipt and disposition of all medications managed by the facility in sufficient detail for an accurate reconciliation. (1) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued controlled medications and biologicals according to acceptable standards of practice by one of the following combinations: (A) Two licensed nurses; or (B) a licensed nurse and a licensed pharmacist. (2) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued non-controlled medications and biologicals according to acceptable standards of practice by any of the following combinations: (A) Two licensed nurses; (B) a licensed nurse and a medication aide; (C) a licensed nurse and a licensed pharmacist; or	S3216		

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S3216	Continued From page 15 (D) a medication aide and a licensed pharmacist. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(i) The facility reported a census of 22 residents. The sample included 3 residents. Based on observation and interview for 3 (# 204, #205, #206) non-sampled residents, the operator failed to ensure licensed nurses and medication aides shall maintain records of the receipt and disposition of all medications managed by the facility in sufficient detail for an accurate reconciliation. Findings included: - Observation of medication room during entrance tour on 8-10-16 at 10:17 a.m. with licensed staff A revealed the top shelf of upper cabinet above sink labeled "medications to be destroyed" which contained the following: For resident #204: Fluvoxamine 100 milligram (mg) tablets (tab), one card with one tab filled 5-23-16 and one card with 14 tabs filled 6-30-16. For resident #205: Potassium Chloride 20 milliequivalents 30 tabs filled on 7-7-16. Levofloxacin 500 mg 10 tabs filled on 7-18-16. For resident #206: Amoxicillin 500 mg two cards with 2 tabs each filled on 7-22-16. Interview on 8-10-16 at 10:17 a.m. with certified staff B stated the above medications were for current residents and had been discontinued by the physician. Stated when medications were discontinued or expired them were removed from	S3216		

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S3216	Continued From page 16 cart and placed on the top shelf and "not logged until we destroy them." Review of facility policy stated: "Discontinued medication will be removed from medication cart and logged on a medication disposition sheet. Medication will be counted with an accurate count logged on this sheet. Medication will then be placed in a secure cabinet in the medication room. If medication meets requirements it can be returned to pharmacy for credit. If it does not meet requirements, it will be destroyed per policy in facility with pharmacist." Interview on 8-15-16 at 12:10 p.m. with operator confirmed staff failed to follow facility policy to log medications when removed from medication cart and placed for destruction or return to pharmacy. For residents #204, #205, #206, the operator failed to ensure licensed nurses and medication aides shall maintain records of the receipt and disposition of all medications managed by the facility in sufficient detail for an accurate reconciliation.	S3216		
S3261 SS=D	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action This REQUIREMENT is not met as evidenced by:	S3261		

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S3261	Continued From page 17 KAR 26-41-105(f)(11) The facility reported a census of 22 residents. The sample included 3 residents. Based on record review and interview for 1 of 3 sampled residents, the operator failed to ensure documentation of all incidents including the date, time of occurrence, action taken and results of the action. Findings included: - Record review for resident #201 revealed admission on 7-7-16 with diagnoses Dementia with Psychosis, Hyperlipidemia, Gastroesophageal Reflux Disease, and Depression/Anxiety. The Functional Capacity Screen dated 7-7-16 recorded resident required health care services. The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 7-7-16 recorded services for facility staff to provide assistance with bathing twice weekly; monitor resident's ambulation in common areas and store, set-up, administer and reorder medications. Fax Communication Sheet dated 7-26-16 stated: "Order for psych therapy with home health." The record lacked documentation of resident receiving home health services for psych therapy. Interview on 8-10-16 at 3:25 p.m. with licensed staff A stated resident was to receive services and a home health agency sent a social worker to see resident. The resident adamantly refused services and "kicked the psych person out of his/her room". Confirmed the record lacked	S3261		

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S3261	Continued From page 18 documentation of residents refusal of services including notification of physician that resident did not receive and did not want the services. For resident #201, the operator failed to ensure documentation of visit from home health staff, resident's refusal of psych services and notification of the physician of resident's refusal.	S3261		