| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235187 | A. Building<br>B. Wing | 09/14/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Mission Point Nsg Phy Rehab Ctr of Madison Heights | 31155 Dequindre<br>Madison Heights, MI 48071 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568<br><br>This citation pertains to Intake Number(s): #MI00130650.<br><br>Based on observation, interview, and record review, the facility failed to ensure a resident with known impulsive, violent behaviors did not physically abuse another resident. This involved three (R703, R704, and R710) of eights residents reviewed for abuse and neglect and resulted in R704 punching and placing R710 in a head lock after R704 had a previous physical altercation with R703. The incident resulted in R710 having a change in their psychosocial well-being which included expressions of feeling terrified and traumatized and altering their daily routine due to fear of R710. Findings include:<br><br>Review of a Facility Reported Incident (FRI) submitted to the State Agency on 8/4/22 revealed the following: Incident Summary Residents had a physical altercation with (R704) being the physical aggressor. (R704) hit (R703) in the chest. Minor injuries treated at facility .Investigation Summary Analysis: .(R703) is wheelchair bound .(R704) .BIMS (Brief Interview of Mental Status) score is 15 which indicated no cognitive impairment. (R704) is ambulatory .According to staff interviews, witness statements, and record review .They observed both (R703) and (R704) lying on the floor wrestling .Residents who were in the area at the time of the incident report both residents having words then (R704) hit (R703) in the chest. Both residents fell to the floor .(R704 was transferred to the hospital for an evaluation related to a change in behavior/aggressiveness . Administrator interviewed (R703) regarding the incident on 8/4/22 at approximately 9:15 AM. (R703) stated that (R704) called him a crippled and he called (R704) a pedophile. That's when (R704) pushed/hit him in the chest and they fell to the floor and wrestled .Administrator interviewed (R704) regarding the incident .(R704) stated that (R703) called him a pedophile and commended on his facial hair upsetting him. He stated that he pushed/hit (R703) in the chest .because of what he called him .<br><br>An onsite investigation was conducted on 9/13/22 and 9/14/22.<br><br>Review of R704's clinical record revealed R704 was admitted into the facility on [DATE], readmitted on [DATE], and discharged to the hospital on 9/9/22 with diagnoses that included: encephalopathy, paranoid schizophrenia, head injury, and anxiety disorder. Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed 704 had intact cognition and was ambulatory with supervision.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|
| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of a SNF/NF (Skilled Nursing Facility/Nursing Facility) to Hospital Transfer Form revealed R704 was transferred to the hospital on 8/4/22. The form indicated R704 was Physical aggressive toward peers/staff.<br><br>Review of R704's care plans revealed a care plan was not developed with interventions to address R704's aggressive and violent behaviors until 9/7/22 (approximately one month after R704 hit R703 in the chest).<br><br>Review of R704's progress notes revealed a Nursing Progress Note dated 9/5/22 at 10:47 AM that read, Patient was outside smoking and assumed another patient had his cigarettes (which was not his) he walked over to her and grabbed her and shook the other patient also to mention patient is picking up cigarette butts behind other patients smoking them.<br><br>On 9/13/22, the Administrator was asked to provide any additional investigations or incident reports for R704 besides the FRI submitted to the State Agency on 8/4/22. The Administrator reported he had another FRI that was submitted to the State Agency and he was still conducting the investigation.<br><br>Review of an incident report dated 9/5/22 at 11:33 AM, completed by Nurse 'D', revealed, Nursing Description: patient (R704) verbally hit another patient while in the courtyard smoking cigarette. Resident Description: patient (R704) stated another resident put an empty cigarette box in his hoodie and he turned around and grabbed the resident in a headlock .ambulatory without assistance .Witnesses .(Certified Nursing Assistant - CNA 'E') .<br><br>Review of the information submitted to the State Agency revealed the other resident involved was R710.<br><br>On 9/13/22 at 2:26 PM, a telephone interview was conducted with CNA 'E'. CNA 'E' was asked to describe what occurred between R704 and R710 on 9/5/22. CNA 'E' reported he was assigned to take the residents out to the courtyard to smoke and while he was assisting residents outside, he heard raised voices from residents in the courtyard. CNA 'E' explained that he observed R704 with R710 in a headlock. CNA 'E' reported R710 and the other residents explained that R710 attempted to throw away an empty cigarette box in the trash that was on the ground, R704 picked it up and threw it onto the ground, R710 placed the cigarette box in the hood of R704's sweatshirt and that was when he put her in a headlock. CNA 'E' reported he was able to redirect R704 away from R710 but that R710 was riled up and really scared and apologized to (R704) for putting the box in his hood. CNA 'E' explained he stayed with the residents until they finished smoking, then reported the incident to the nurse and the Director of Nursing (DON). CNA 'E' further reported that R704 was not allowed to go out to smoke after that, but continued to force his way through the door into the courtyard and was smoking cigarette butts off the ground. When queried about any known violent behaviors prior to physically attacking R710, CNA 'E' reported he heard from other staff that he would cuss at the nurses and make threats to kill them. CNA 'E' reported other residents expressed discomfort after the incident due to R704's size and mentality.<br><br>(continued on next page) |

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| Mission Point Nsg Phy Rehab Ctr of Madison Heights | 31155 Dequindre<br>Madison Heights, MI 48071 |

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|---|---|
| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 9/13/22 at 2:47 PM, R710 was observed sitting up on bed. R710 was asked about any incidents that occurred with other residents. R710 explained the previous week prior to going out to smoke in the courtyard, the residents who smoked were asked to ensure they did not litter outside if they wanted to continue with their smoking privileges. While outside, R710 picked an empty cigarette box up from the ground and attempted to throw it out, but it fell on to the ground again. R704 picked up the cigarette box and threw it back onto the ground and R710 jokingly placed the box in the hood of R704's sweatshirt. R710 explained that immediately, R704 turned around, grabbed her head, and put her into a headlock, and punched her in the face. R710 stated, I was terrified! R710 explained that R704 was very tall and big. R710 was observed to have petite stature. R710 reported R704 was not supposed to go out to smoke with the other residents after the incident occurred but he would force his way into the courtyard. R710 explained she ended up not going out to smoke because the situation was so traumatizing to her. R710 further explained that R704 remained in the facility for a couple days after he attacked her and that he had been violent with another resident previously.<br><br>On 9/13/22 at approximately 2:52 PM an interview was conducted with R705. When queried about safety in the facility, R705 reported that they felt safe, but reported they had witnessed an incident involving a male and female resident (hereinafter identified as R704 and R710) about a about a week ago. The incident occurred in the outside courtyard while on a smoking break. R705 explained that R704 dropped a cigarette pack on the ground and R710 then put a cigarette box in R704's hood of their jacket. R704 then grabbed at her (R710) neck and held her tightly and hit her. R705 further reported that the police came out and noted that R704 was acting crazy.<br><br>On 9/13/22 at 3:56 PM, a telephone interview was conducted with Nurse 'D'. When queried about the incident that occurred on 9/5/22 between R704 and R710, Nurse 'D' reported she did not witness the incident but it was reported to her by CNA 'E'. Nurse 'D' reported R704 was not allowed to go out to smoke after the incident occurred, but he was very adamant and would force his way out. Nurse 'D' reported that at one point R704 walked toward R710 and R710 ran away from him and hid behind Nurse 'D'.<br><br>On 9/13/22 at 4:55 PM, the DON was interviewed. When queried about the incident that occurred between R704 and R710 on 9/5/22, the DON reported CNA 'E' reported the incident to him and he spoke with R704 the day of the incident and R710 the following day. The DON reported on the day of the incident, R710 was quite distraught and did not want to speak with anyone. The DON explained that R704 was told he would not go out to smoke after the incident, but that he did end up going out on a couple occasions and had to be redirected inside. When queried about what interventions were implemented after R704 hit R703 in the chest on 8/4/22, the DON reported those two residents were separated and R703 was talked to about how verbal insults could trigger physical behaviors from R704. The DON did not mention any interventions to prevent other residents from being physically abused by R704.<br><br>On 9/13/22 at 4:40 PM, the Administrator was interviewed. When queried about the incident that occurred between R704 and R710 on 9/5/22, the Administrator reported he found out about the incident on 9/7/22 and they attempted to get R704 another placement and when that did not occur, they petitioned R704 out to the hospital. The Administrator reported had he known on 9/5/22 that R704 put R710 in a headlock, he would have petitioned him to the hospital immediately.<br><br>Review of R710's clinical record revealed R710 was admitted into the facility on [DATE] with diagnoses that included: alcohol induced pancreatitis.<br><br>(continued on next page) |

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| Mission Point Nsg Phy Rehab Ctr of Madison Heights | 31155 Dequindre<br>Madison Heights, MI 48071 |

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|---|---|
| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of a facility policy titled, Abuse, Neglect and Exploitation, revised 6/2022, revealed, in part, the following: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse . |

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|---|---|
| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568<br><br>This citation pertains to Intake Number(s): #MI00130650.<br><br>Based on interview, and record review, the facility failed to report an incident of physical abuse between two (R704 and R710) of eight residents reviewed for abuse to the Administrator and the State Agency within the required timeframe, resulting in delayed investigation and implementation of interventions to prevent further abuse. Findings include:<br><br>Review of a facility policy titled, Abuse, Neglect and Exploitation, revised 6/2022, revealed, in part, the following: .The facility will implement the following: .Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other requires agencies (e.g., law enforcement when applicable) within specified timeframes: Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury .<br><br>Review of R704's clinical record revealed R704 was admitted into the facility on [DATE], readmitted on [DATE], and discharged to the hospital on 9/9/22 with diagnoses that included: encephalopathy, paranoid schizophrenia, head injury, and anxiety disorder. Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed 704 had intact cognition and was ambulatory with supervision.<br><br>Review of R704's progress notes revealed a Nursing Progress Note dated 9/5/22 at 10:47 AM that read, Patient was outside smoking and assumed another patient had his cigarettes (which was not his) he walked over to her and grabbed her and shook the other patient also to mention patient is picking up cigarette butts behind other patients smoking them.<br><br>On 9/13/22, the Administrator was asked to provide any additional investigations or incident reports for R704. The Administrator reported he had a Facility Reported Incident (FRI) that was submitted to the State Agency and he was still conducting the investigation.<br><br>Review of an incident report dated 9/5/22 at 11:33 AM, completed by Nurse 'D', revealed, Nursing Description: patient (R704) verbally hit another patient while in the courtyard smoking cigarette. Resident Description: patient (R704) stated another resident put an empty cigarette box in his hoodie and he turned around and grabbed the resident in a headlock .ambulatory without assistance .Witnesses .(Certified Nursing Assistant - CNA 'E') .<br><br>Review of the information submitted to the State Agency revealed the other resident involved was R710 and the incident was reported to the State Agency on 9/7/22 at 11:59 AM (two days after the incident occurred).<br><br>(continued on next page) |

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|---|---|
| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 9/13/22 at 2:26 PM, a telephone interview was conducted with CNA 'E'. CNA 'E' was asked to describe what occurred between R704 and R710 on 9/5/22. CNA 'E' reported he was assigned to take the residents out to the courtyard to smoke and while he was assisting residents outside, he heard raised voices from residents in the courtyard. CNA 'E' explained that he observed R704 with R710 in a headlock. CNA 'E' reported R710 and the other residents explained that R710 attempted to throw away an empty cigarette box in the trash that was on the ground, R704 picked it up and threw it onto the ground, R710 placed the cigarette box in the hood of R704's sweatshirt and that was when he put her in a headlock. CNA 'E' reported he was able to redirect R704 away from R704 but that R710 was riled up and really scared and apologized to (R704) for putting the box in his hood. CNA 'E' explained he stayed with the residents until they finished smoking, they reported the incident to the nurse and the Director of Nursing (DON). CNA 'E' further reported that R704 was not allowed to go out to smoke after that, but continued to force his way through the door into the courtyard and was smoking cigarette butts off the ground. When queried about any known violent behaviors prior to physically attacking R710, CNA 'E' reported he heard from other staff that he would cuss at the nurses and make threats to kill them. CNA 'E' reported other residents expressed discomfort after the incident due to R704's size and mentality.<br><br>On 9/13/22 at 2:47 PM, R710 was observed sitting up on bed. R710 was asked about any incidents that occurred with other residents. R710 explained the previous week prior to going out to smoke in the courtyard, the residents who smoked were asked to ensure they did not litter outside if they wanted to continue with their smoking privileges. While outside, R710 picked an empty cigarette box up from the ground and attempted to throw it out, but it fell on to the ground again. R704 picked up the cigarette box and threw it back onto the ground and R710 jokingly placed the box in the hood of R704's sweatshirt. R710 explained that immediately, R704 turned around, grabbed her head, and put her into a headlock, and punched her in the face. R710 stated, I was terrified! R710 explained that R704 was very tall and big. R710 was observed to have petite stature. R710 reported R704 was not supposed to go out to smoke with the other residents after the incident occurred but he would force his way into the courtyard. R710 explained she ended up not going out to smoke because the situation was so traumatizing to her. R710 further explained that R704 remained in the facility for a couple days after he attacked her and that he had been violent with another resident previously.<br><br>On 9/13/22 at 3:56 PM, a telephone interview was conducted with Nurse 'D'. When queried about the incident that occurred on 9/5/22 between R704 and R710, Nurse 'D' reported she did not witness the incident but it was reported to her by CNA 'E'. Nurse 'D' reported R704 was not allowed to go out to smoke after the incident occurred, but he was very adamant and would force his way out. Nurse 'D' reported that at one point R704 walked toward R710 and R710 ran away from him and hid behind Nurse 'D'. Nurse 'D' explained she reported the incident to the DON.<br><br>On 9/13/22 at 4:40 PM, the Administrator, who was the Abuse Coordinator for the facility, was interviewed. When queried as to when he was notified about R704 putting R710 in a headlock on 9/5/22, the Administrator reported he was on vacation and was not notified until Wednesday (9/7/22). The Administrator reported it should have been reported to him immediately and had he known about the incident on 9/5/22, R704 would have been petitioned to the hospital for a psychiatric evaluation immediately. The Administrator reported that once he found out on 9/7/22, an alternative placement was looked into, but it did not work out, so R704 was petitioned to the hospital on 9/9/22 (four days after the incident occurred on 9/5/22).<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 9/13/22 at 4:55 PM, the DON was interviewed. When queried about the incident that occurred between R704 and R710 on 9/5/22, the DON reported he was in the building when it occurred and CNA 'E' reported that R704 put R710 in a headlock. The DON reported he notified the Administrator the following day, took a statement from R704 and then talked to R710 the following day because R710 was quite distraught and did not want to speak with anyone. When queried about whether he would have been the staff person responsible for reporting the incident to the State Agency in the absence of the Administrator, the DON reported the next person in charge would have been the Regional Director of Operations. The DON reported he did not notify the Regional Director of Operations or the State Agency on 9/5/22.<br><br>On 9/13/22 at 4:40 PM, the Administrator was interviewed. When queried about the incident that occurred between R704 and R710 on 9/5/22, the Administrator reported he found out about the incident on 9/7/22 and they attempted to get R704 another placement and when that did not occur, they petitioned R704 out to the hospital. The Administrator reported had he known on 9/5/22 that R704 put R710 in a headlock, he would have petitioned him to the hospital immediately.<br><br>Review of R710's clinical record revealed R710 was admitted into the facility on [DATE] with diagnoses that included: alcohol induced pancreatitis. Review of R710's progress notes revealed no documentation of R710 being physically abused by another resident. There was no documentation that R710 was evaluated by the social services department until 9/9/22 (four days after the incident and the day R704 was discharged from the facility). |

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|---|---|
| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675<br><br>This citation pertains to intake #s: MI00130824, and MI00131055.<br><br>Based on observation, interview and record review, the facility failed to ensure residents were consistently receiving routine ADL (activities of daily living) care including showers/baths for three (R701, R702 and R707) of four residents reviewed for ADL care.<br><br>Findings include.<br><br>Complaints filed with the State Agency (SA) alleged residents were not receiving routine ADLs including showers/baths.<br><br>According to the facility's policy titled, AL: Basic Care Services dated 6/1/2022, .Residents will receive a full shower/bath weekly based on care preferences .<br><br>R707<br><br>On 9/13/22 at 10:16 AM, res was asleep and snoring, but woke up upon approach. There was strong stale urine and bowel movement (BM) odor in the room. The resident was alert and oriented. When asked about the frequency of showers and/or baths, R707 reported concerns that they had not been receiving them until just this week. When asked about the strong urine/BM odor, they reported they were waiting for staff to find new briefs and was due to be changed.<br><br>Review of the clinical record revealed R707 was admitted into the facility on [DATE] with diagnoses that included: amyotrophic lateral sclerosis, type 2 diabetes mellitus without complications, blindness right and left eye, and flaccid hemiplegia affecting left nondominant side. According to the Minimum Data Set (MDS) assessment dated [DATE], R707 had no communication concerns, had some moderate cognitive impairment, had no behavioral concerns; and required extensive assistance of one-person physical assist for personal hygiene and bathing.<br><br>Review of the care plans and Kardex revealed there was no documentation that identified any behavioral concerns for R707 such as refusing ADL care.<br><br>R707's ADL care plan initiated 9/8/21 included an intervention last revised on 3/28/22 which read, Shower/Bathing/Bed Bath Scheduled (which was twice weekly) - extensive assist/1 staff.<br><br>On 9/13/22 at 4:40 PM, the Administrator reported the shower schedules were kept in a binder at the nursing desk and that the facility documented showers in the electronic clinical record. No longer used hard paper to document showers.<br><br>Review of the shower/bath schedule for R707 revealed they were scheduled to receive shower/bath on Tuesdays and Fridays on the 3:00 PM to 11:00 PM shift.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 9/14/22 at 8:45 AM, an interview was conducted with Unit Manager (Nurse 'B'). When asked about the shower documentation, they reported that would be documented in POC (Point of Care - a section of the electronic medical record). When asked if a resident had refused or declined a shower, where that would be documented, Nurse 'B' reported that would be noted in the POC documentation or also in a nursing progress note.<br><br>On 9/14/22 at 9:35 AM, Nurse 'B' was asked to review R707's clinical record and upon review, confirmed the resident had not received showers/baths per their plan of care. Nurse 'B' reported R707 had behaviors of refusing care, however upon review of the progress notes, Kardex, and care plans there was no documentation that staff had attempted to provide showers/baths and the resident refused. Nurse 'B' further reported that showers/baths should be provided twice a week.<br><br>34275<br><br>R701<br><br>On 9/13/22 at approximately 9:48 AM, R701 was observed sitting in their wheelchair near the nurse's station. The resident had long unkempt greasy hair as well as long chin hairs. The resident was alert but confused and not able to answer questions asked.<br><br>Review of the clinical record revealed R701 was admitted into the facility on [DATE] with diagnoses that included: hypothyroidism, dysphasia, dementia without behavioral disturbance and psychotic disorder with delusions.<br><br>According to the Minimum Data Set (MDS) assessment dated [DATE], R701 was severely cognitively impaired and required extensive one-person physical assist for personal hygiene and bathing.<br><br>Review of the care plans and Kardex revealed there was no documentation that identified any behavioral concerns for R701 such as refusing ADL care.<br><br>Review of the shower/bath schedule for R701 revealed they were scheduled to receive shower/bath on Wednesday and Saturday on day shift 7:00 AM to 3:00 PM. Review of the POC for a 30-day look-back noted the resident had received showers only on 8/17/22, 8/20/22, 8/31/22 and 8/28/22. There was no further documentation that noted the resident had refused their shower.<br><br>R702<br><br>On 9/13/22 at approximately 10:02 AM, R702 was observed walking up and down the hall. The resident was alert, but not able to answer any questions asked.<br><br>A review of R702's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included: dementia without behavioral disturbance, psychotic disturbance, and mood disorder. A review of the resident's MDS revealed the resident was severely cognitively impaired and required extensive one-person physical assist for personal hygiene and bathing.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235187 | A. Building<br>B. Wing | 09/14/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Mission Point Nsg Phy Rehab Ctr of Madison Heights | 31155 Dequindre<br>Madison Heights, MI 48071 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the shower/bath schedule for R702 revealed they were scheduled to receive shower/bath on Tuesday and Friday on day shift 7:00 AM to 3:00 PM. Review of the POC for a 30-day look-back noted the resident had received showers only on 8/30/22, 9/6/22 and 9/13/22. There was no further documentation that noted the resident had refused their shower.<br><br>On 9/14/22 at approximately 9:40 AM, Nurse B reported that all shower sheets are noted in the resident's electronic record. When asked about R701 and R702, Nurse B reported that R701 often refuses showers and attempts to removal facial hair. When asked to provide any documentation that showed R702 refused ADL care, Nurse B was only able to provide a section of the resident 701's care plan that noted: .I can be aggressive at times toward staff .I will scream, hit, yell, use foul language, stomp my feet when ADL care or bathing is being provided. Intervention: . offer resident to perform ADL's on her own .with staff oversight . Again, there was no documentation noted that the resident refused their shower and/or interventions were attempted. |