STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155221	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster Village Health & Rehab	1120 E Davis Dr Terre Haute, IN 47802

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38847 Based on interview and record review, the facility failed to ensure a resident-centered behavior management care plan was developed and interventions were identified and attempted during behavioral episodes prior to the resident being transferred to the emergency room (ER) for behaviors for 1 of 3 residents reviewed for quality of care (Resident B). Findings include: During an interview, on 3/20/25 at 11:19 a.m., Hospital Employee 8 indicated Resident B presented to the ER, on 2/20/25, and the facility reported the resident had aggressive behaviors. The resident did not have behaviors in the ER, and there was no medical reason to admit him to the hospital, so they attempted to send him back to the facility. The Administrator refused to allow him to return to the facility and indicated they would not accept him back until he had a psychiatric evaluation. The resident had recently had a medication change, and the hospital provider thought the behaviors might have been due to the change. The Hospital Employee notified the facility the hospital did not have 24-hour psychiatric evaluations available, and this situation was not an emergency. The resident was hospitalized from 2/21/25 to 3/6/25 when he was discharged to a different skilled nursing facility (SNF). During his hospital stay, the resident had some behaviors but was never actually physically aggressive with the staff. Resident B's record was reviewed on 3/20/25 at 1:09 p.m. Census information indicated the resident was admitted to the facility on [DATE] and discharged on [DATE]. Diagnoses on the resident's profile included, but were not limited to, unspecified encephalopathy (impairment in the brain's function), unspecified mood disorder, and mild cognitive impairment with uncertain or unknown etiology. A Progress Note, dated 1/10/25, indicated the resident was admitted to the facility and was agitated and rude upon admission. A Progress Note, dated 1/11/25, indicated when staff provided care to the resident he stated, Stop you're trying to molest me. The incident was reported to the Administrator and Director of Nursing (DON). Staff was instructed to provide care in pairs. The note lacked documentation of interventions attempted at the time of the behavior. (continued on next page)

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

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

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Behavior Progress Note, dated 1/11/25, indicated the resident stated staff was trying to molest him during activities of daily living (ADL) care. When the writer spoke with the resident, the resident indicated the staff was not inappropriate with him, but he did not like peri care (cleaning the genital and anal area) being provided. The resident was educated related to his physical needs for care due to his incontinence, and the resident agreed. The note lacked documentation of the resident's level of understanding of the education considering his cognitive impairment or interventions for the staff to attempt when the resident exhibited behaviors. A care plan, initiated on 1/11/25, indicated the resident had a potential for impaired behavioral patterns related to restlessness, agitation, false accusations towards staff, physical behaviors towards staff, refusal of care, and verbal behaviors towards staff. Interventions indicated anticipate and meet the resident's needs, approach the resident in a calm manner, behavioral health services consult as ordered, offer to call the resident's wife, reapproach in 10 to 15 minutes, and care in pairs. The care plan lacked resident-specific interventions. A care plan, initiated on 1/11/25, indicated the resident received an antidepressant. Interventions were generalized and included educate the resident, family, and caregivers about risks, benefits, and side effects or toxic symptoms of specify: anti-depressant drugs being given, give antidepressant medications as ordered by the physician and monitor/document side effects and effectiveness, and monitor/document/report to the physician as needed with ongoing signs and symptoms of depression that were unaltered by the antidepressant medication. The care plan lacked resident-specific interventions. A care plan, initiated on 1/11/25, indicated the resident received an antipsychotic. Interventions were generalized and included administer medication as ordered, abnormal involuntary movements scale (AIMS) (assessment for medication-related involuntary movements) every six months and as needed, and behavioral health services consult as ordered. The care plan lacked resident-specific interventions. A Behavior Progress Note, dated 1/14/25 at 3:28 p.m., indicated the writer intervened when the resident was combative with care and staff when he was leaving for dialysis (treatment to remove waste from the blood when the kidneys do not function). The resident continued to be verbally inappropriate, but physical behaviors were reduced. The resident remained care in pairs, and the staff was educated to provide a slow easy approach. The note lacked documentation of resident-centered interventions developed or implemented or the efficacy of interventions provided. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Progress Note, dated 1/14/25 at 11:11 p.m., indicated the Certified Nurse Aide (CNA) reported to the nurse the resident refused care earlier in the shift and insisted he was in the wrong room. When the nurse approached the resident, the resident indicated he thought he was moving rooms but guessed not. The nurse explained to the resident he was in the correct room, and staff would assist him to bed when he was ready. The resident was agreeable. When the CNAs approached at a later time, the resident refused and became irritated with staff. The nurse advised the CNAs to give the resident more time as he might not have been ready for bed yet. During shift change, the night shift CNA reported the resident was sitting on the side of the bed clinging tightly to his wheelchair and refused to allow anyone to move it. The resident was verbally aggressive with the CNA. The nurse entered the resident's room to find the resident clinging to the wheelchair while sitting on the side of the bed. The CNAs stated they had not assisted him to bed, and the resident confirmed he put himself to bed. The nurse requested permission to move the resident's wheelchair to provide more room, and the resident angrily refused and became verbally aggressive with staff. The nurse advised the resident moving the wheelchair would have been safer, but the resident refused again. The resident threatened to hit the staff and balled his fist. The nurse advised the resident this was not appropriate behavior and requested he not do this. The resident falsely accused the staff of threatening to hit the resident. The nurse advised the resident this was incorrect and staff was trying to assist him into bed. The resident stated, I've been doing this myself for years, I don't need help now. The nurse stood back quietly as the resident continued to assist himself into bed. The resident was able to bring his legs into bed and adjusted the bed using the bed remote. The resident was calmer after he adjusted himself in bed and was given the call light. The resident was reminded staff needed to be present for all transfers due to safety, and the resident expressed understanding. The note lacked documentation the resident was able to understand reminders and education considering his cognitive impairment or the CNAs were educated on how to safely allow the resident to perform his own ADLs safely if this was an intervention to alleviate behaviors. A Progress Note, dated 1/16/25, indicated the resident refused to allow the staff to change his incontinence briefs. The Administrator and the resident's wife were in the room when the staff attempted to provide the care, and the resident kept threatening to hit staff. The care was to be re-attempted later throughout the evening and night. The note lacked documentation of interventions provided when the behavior occurred and the resident's response. A Physician's Order was dated 1/30/25 and discontinued on 2/12/25. The order indicated quetiapine 25 milligrams (mg) by mouth once daily for behaviors. A Skin and Wound Note, dated 1/31/25, indicated the writer spoke with the resident about care refusals, and the resident allowed a skin assessment to be completed. The resident had a stage two pressure ulcer (partial-thickness skin loss) to his buttock. The resident would not allow enough time for the nurse to assess the area adequately and refused a dressing. A Social Services Progress Note, dated 1/31/25 at 11:21 a.m., indicated a psychiatric services consent was received and sent to the provider. The resident's verbal behaviors and rejection of care continued to occur. The note lacked documentation of resident-specific interventions developed or implemented to manage the resident's behaviors. A Progress Note, dated 1/31/25 at 12:12 p.m., indicated the resident refused to take his medications or be weighed. The interdisciplinary team (IDT) was notified. The note lacked documentation of resident-specific interventions developed or implemented to manage the resident's behaviors. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Progress Note, dated 2/1/25, indicated a Qualified Medication Aide (QMA) notified the nurse the resident had an area on his buttocks. The CNAs reported the area was found when they provided incontinence care. The resident refused to allow the nurse to perform a skin assessment. The note lacked documentation of resident-specific interventions developed or implemented to manage the resident's behaviors. A Progress Note, dated 2/2/25 at 9:07 a.m., indicated the resident refused to let the nurse, CNA, and another nurse to provide incontinence care. The resident hit and tried to bite staff. The resident stated, F--- you, to the nurse. The resident had an area on his buttocks that needed cared for, but the resident refused to let the staff look at it. The note lacked documentation of resident-specific interventions developed or implemented to manage the resident's behaviors. A Progress Note, dated 2/2/25 at 12:33 p.m., indicated the resident's wife came in to visit the resident, and the nurse asked the resident's wife to be in the room when staff attempted to provide incontinence care. The resident's wife was happy to help and encouraged the resident to allow staff to provide incontinence care. The resident agreed and allowed the care to be provided. A Therapy Progress Note, dated 2/3/25, indicated the therapy staff member entered the room with the resident's wife and spoke with the resident about sitting up on the edge of the bed. The therapy staff member placed a hand under the resident's left foot to support the resident's legs and moving to the edge of the bed. The resident yelled at the therapy staff member and his wife, Don't touch me. I can do it myself. The resident asked for the bed controller and then pushed all of the buttons. The resident's wife took the bed controller and encouraged the resident to sit on the edge of the bed. The resident asked the therapy staff member to to assist, and the resident required max assist to sit on the edge of the bed. The resident refused to scoot towards the edge and demanded the bed was lowered. The therapy staff member placed the resident's rolling walker in front of the resident, and the resident stated, I don't want that, I want the chair, and pushed the rolling walker at his wife. The therapy staff member brought the wheelchair, placed it perpendicular to the bed, and asked the resident to stand up to transfer to the wheelchair. The resident called the therapy staff member a f------ idiot, and tried to hit the therapy staff member and his wife in anger. The resident then placed the wheelchair directly in front of where he was sitting on the edge of the bed. The therapy staff member provided education on safe placement, and the resident's wife understood. The resident threatened to hit the therapy staff member in the mouth and stated, Get the f--- out of my room, and began mimicking everything the therapy staff member said. The resident's wife apologized to the therapy staff member, and the resident demanded his wife take him home today and attempted to hit her again. The resident was very difficult to re-direct at times. Several times during the treatment the resident attempted to hit the therapy staff member and his wife and used inappropriate verbiage. The note lacked documentation of resident-specific interventions developed or implemented to manage the resident's behaviors. The Administrator provided an untitled document on 3/20/25 at 2:30 p.m., updated on 2/3/25, and indicated it was the resident's information from the intervention binder. The interventions listed were offer to call wife, reapproach in 10 to 15 minutes, and care in pairs. The document lacked resident-specific interventions. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An admission Minimum Data Set (MDS) Assessment, dated 2/6/25, indicated the resident had moderate cognitive impairment. The resident exhibited physical and verbal behavioral symptoms directed towards others one to three days of the look-back period. The behaviors put the resident at a significant risk of physical illness or injury, significantly interfered with the resident's care and participation in activities or social interactions. The behaviors put others at a significant risk of physical injury, significantly intruded on the privacy or activities of others, and significantly disrupted the care or living environment of others. The resident rejected care four to six days of the look-back period. The resident was dependent on staff for toileting hygiene, upper and lower body dressing, chair to bed transfers, and tub and shower transfers and required substantial/maximal assistance with personal hygiene. The resident was always incontinent of bowel and bladder. The resident received an antipsychotic and antidepressant medication during the look-back period. A care plan, initiated on 2/7/25, indicated the resident had impaired cognitive function/dementia or impaired thought processes. Interventions were generalized and included approach the resident in a calm, gentle manner, communicate with the resident/family/caregivers about the resident's capabilities, and discuss concerns about confusion, disease process, and community placement with the resident/family/caregivers. The care plan lacked resident-specific interventions. A Behavior Progress Note, dated 2/7/25 at 6:05 a.m., indicated the CNAs were in the resident's room to provide care, and during the linen change the resident grabbed the CNA's forearm with both hands and yelled at her. The CNAs finished providing care to the resident and left the room. The note lacked documentation of resident-specific interventions developed or implemented to manage the resident's behaviors. A Behavior Progress Note, dated 2/7/25 at 1:41 p.m., indicated the resident was overheard refusing therapy. Therapy made several attempts, and the writer attempted to provide assistance. The resident refused. The writer assisted the CNAs and the resident's wife with the resident's ADL care. The resident grabbed one of the CNA's hand and arm and refused to let go. The resident was informed he was hurting the CNA, and the resident replied he knew how far to go before he caused pain. The nurse was able to redirect the resident, and he released the CNA's hand and arm. The note lacked documentation of resident-specific interventions developed or implemented to manage the resident's behaviors. A Social Services Progress Note, dated 2/10/25 at 8:14 a.m., indicated the resident continued to be verbally and physically aggressive with staff. Social Services spoke with the resident's wife and she was agreeable to an acute psychiatric stay referral. The note lacked documentation of resident-specific interventions developed or implemented to manage the resident's behaviors. A Social Services Progress Note, dated 2/10/25 at 10:04 a.m., indicated the resident was referred to two acute psychiatric units, but both declined to accept him for admission. A Progress Note, dated 2/10/25 at 1:40 p.m., indicated the resident continued to refuse medications and care. The CNA and nurse attempted to provide the care three times, but the resident refused. The resident often stated, Get out of here. I don't want anything from you. Management, physician, and the resident's spouse were notified. The note lacked documentation of resident-specific interventions developed or implemented to manage the resident's behaviors. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Social Services Progress Note, dated 2/10/25 at 3:12 p.m., indicated the resident continued to refuse medications. The note lacked documentation of resident-specific interventions developed or implemented to manage the resident's behaviors. A Progress Note, dated 2/10/25 at 5:29 p.m., indicated the resident continued to refuse medication and care. The resident became verbally and physically abusive with staff. Redirection was attempted without success. Management and the resident's family were notified. The note lacked documentation of resident-specific interventions developed or implemented to manage the resident's behaviors. A Progress Note, dated 2/11/25, indicated the resident refused breakfast and morning medication. The CNA attempted twice and the nurse attempted twice. The resident laughed at the nurse and did not stop laughing the entire time the nurse provided care to the resident's roommate. The DON and Unit Manager were aware of the abnormal behavior. The note lacked documentation of resident-specific interventions developed or implemented to manage the resident's behaviors. A Behavior Note, dated 2/12/25 at 12:31 p.m., indicated the resident refused medication and wound care after three attempts. The resident's wife was notified and reported the resident was being extremely mean. When the resident asked his wife to open the blinds, and she went over to the blinds he told her she was not a nurse. The nurse opened the blinds for the resident and redirected the behavior. The note lacked documentation of resident-specific interventions developed or implemented to manage the resident's behaviors. A Psychiatry Initial Consult, dated 2/12/25, indicated the resident was seen for initial psychiatric medication management for conditions including mood disorder, mild cognitive deficit, and insomnia. The resident's symptoms were chronic, moderate in severity, ongoing, intermittent, and responded to medication. The resident was sitting up on the side of his bed with his sweatpants at his knees. His wife reported she was trying to get him to stand up for awhile, but he refused. The staff reported the resident was aggressive with any care given or attempted by anyone, refused medications periodically, and was verbally abusive. The resident was not a danger to himself or others. The aggression was physical and verbal, towards staff. Depakote (mood stabilizer) sprinkles 125 mg by mouth twice daily was started for chronic, symptomatic mood disorder. A Social Services Progress Note, dated 2/12/25 at 3:31 p.m. indicated the facility's psychiatric service provided saw the resident and ordered Depakote for mood disorder. A Progress Note, dated 2/12/25 at 6:58 p.m., indicated the resident was seen earlier in the day by the psychiatric nurse practitioner (NP). The resident's Seroquel (antipsychotic) was discontinued, Depakote was ordered, and a diagnosis was added. A February 2025 Medication Administration Record (MAR), included a Physician's Order, dated 2/13/25. The order indicated behavior monitoring, target behavior false accusations towards staff. If present, document behavior type, intervention, and outcome in progress note, every shift. A February 2025 MAR, included a Physician's Order, dated 2/13/25. The order indicated behavior monitoring, target behavior physical and verbal behaviors/aggression towards staff. If present, document behavior type, intervention, and outcome in progress note, every shift. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A February 2025 MAR, included a Physician's Order, dated 2/13/25. The order indicated behavior monitoring, target behavior refusal of care, personal care, showers, and medications. If present, document behavior type, intervention, and outcome in progress note, every shift. A Progress Note, dated 2/13/25 at 12:21 p.m., indicated the resident refused his medication and blood glucose test and indicated he just wanted to die. The resident indicated he did not want to eat and to take his lunch tray. The DON, Social Services, and Power of Attorney (POA) were notified. The note lacked documentation of resident-specific interventions developed or implemented to manage the resident's behaviors. A Social Services Progress Note, dated 2/13/25 at 2:49 p.m., indicated the Social Services Director (SSD) was one on one with the resident, and he stated he did not want to die and had no plan to harm himself. The resident stated he was hungry and wanted to eat. A Behavior Note, dated 2/14/25, indicated the resident refused morning and afternoon medications and his blood glucose check. The resident's wife was in the room visiting and witnessed the refusal. The IDT was notified. The note lacked documentation of resident-specific interventions developed or implemented to manage the resident's behaviors. A Social Services Progress Note, dated 2/17/25, indicated the resident's wife gave consent to writer to send referral. The note lacked documentation of where, or what type of facility, the resident was referred. A care plan, initiated on 2/20/25, indicated the resident had an alteration in neurological status, encephalopathy. Interventions were generalized and included discuss with resident and family any concerns, fears, and issues regarding diagnosis or treatments, give medications as ordered and monitor/document side effects and effectiveness, monitor intake to ensure adequate fluid intake to prevent dehydration, obtain and monitor lab/diagnostic work as ordered and report results to the physician, pain management as needed and provide alternative comfort measures, and physical therapy (PT) and occupational therapy (OT) evaluate and treat as indicated. The care plan lacked resident-specific interventions. A Behavior Progress Note, dated 2/20/25 at 8:45 a.m., indicated the CNAs assisted the resident with ADLs prior to his dialysis appointment. The CNAs tried to get him up with the assistance of two staff members, but the resident would not assist with the transfer. The CNAs used a Hoyer (mechanical) lift to get him out of bed. As the CNAs adjusted the resident in the lift he kicked one of the CNAs in the abdomen. The physician was notified. The note lacked documentation of resident-specific interventions developed or implemented to manage the resident's behaviors. A Social Services Progress Note, dated 2/20/25 at 1:27 p.m., indicated the resident continued to hit and kick staff, kicked staff in the stomach. The resident remained non-compliant with care. The note lacked documentation of resident-specific interventions developed or implemented to manage the resident's behaviors. A Social Services Progress Note, dated 2/20/25 at 3:06 p.m., indicated the SSD spoke with the resident's wife, and she consented to sending the resident to the ER due to behavioral health. The note lacked documentation of resident-specific interventions developed or implemented to manage the resident's behaviors. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Progress Note, dated 2/20/25 at 3:47 p.m., indicated the resident was sent to the ER for a psychiatric evaluation due to ongoing behaviors and the resident becoming a danger to others at the facility. The resident's wife was at the facility and informed of the plan to transfer the resident. The Progress Notes lacked documentation the resident was a danger to himself or others as his behaviors were directed towards staff. During an interview, on 3/20/25 at 12:14 p.m., CNA 6 indicated she remembered Resident B and had provided care to him when he resided in the facility. The resident had verbal behaviors such as saying things like, Don't touch me or I'll hit you. The resident never actually hit her. The resident kicked at people but had not made contact. The behaviors were not directed towards other residents. The resident had behaviors from the time he was admitted to the facility, and the severity of the behaviors was up and down throughout his stay. During an interview, on 3/20/25 at 1:31 p.m., the Administrator indicated the resident's behaviors gradually increased in severity, he was physically aggressive with staff, and kicked a staff member in the stomach. The resident was sent to the ER for a psychiatric evaluation due to the incident when he kicked a staff member in the stomach. The facility attempted to send him to multiple psychiatric units, but they declined to admit him because he was clinically complex and required dialysis. During an interview, on 3/20/25 at 2:33 p.m., the Administrator indicated there was an intervention binder with interventions for each resident at the nurse's station. The staff should have used it to determine what interventions would have assisted with the resident's behaviors. During an interview, on 3/20/25 at 2:55 p.m., the SSD indicated she remembered Resident B, and he had behaviors of hitting, kicking, yelling, and care refusal. The resident caused harm to a staff member. The resident had behaviors his entire stay at the facility. She was not sure if the resident had a history of behaviors prior to admission to the facility, but they started within 72 hours after admission. At times, the resident's wife was able to help calm him down, but sometimes that made it worse. They reapproached the resident in 10 or 15 minutes and provided care in pairs. She indicated the interventions were not effective but did not indicate resident-specific interventions were identified or attempted. She was not sure if the staff documented what interventions were utilized or their efficacy when the resident had behaviors. The resident's behaviors were not directed towards other residents, and the resident was not a danger to himself or others. All of the resident's behaviors were directed towards staff. The interventions were included in the intervention binder at the nurse's station. During an interview, on 3/20/25 at 3:00 p.m., CNA 10 indicated she remembered the resident, and he had behaviors of saying nonsensical statements, hitting, and kicking. The behaviors were directed towards staff, and the resident bit her before. She was not sure where to find interventions to attempt when the residents had behaviors or what interventions were in place for Resident B. During an interview, on 3/20/25 at 3:05 p.m., Registered Nurse (RN) 4 indicated she remembered the resident. The resident exhibited behaviors of raising his fist, grabbing, and kicking. The behaviors were directed towards staff, and they were ongoing from the time of admission. They tried a slow approach and used trial and error to determine what interventions were effective when the resident had behaviors. There was an intervention binder at the nurse's station, but it was not helpful and they seemed to be out of ideas for interventions. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/20/25 at 2:35 p.m., the Administrator provided an undated document titled, Behavioral Assessment, Intervention and Monitoring, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy Statement: 1. The facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care .Policy Interpretation and Implementation . Assessment .2. As part of the comprehensive assessment, staff will evaluate, based on input from the resident, family, and caregivers, review of medical record and general observations: a. the resident's usual patterns of cognition, mood and behavior; b. the resident's usual method of communicating things like pain, hunger, thirst, and other physical discomforts; c. the resident's typical or past responses to stress, fatigue, fear, anxiety, frustration and other triggers; and d. the resident's previous pattern of coping with stress, anxiety, and depression .Management: 1. The interdisciplinary team will evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident, and develop a plan of care accordingly. Safety strategies will be implemented immediately if necessary to protect the resident and others from harm .2. The care plan will incorporate findings from the comprehensive assessment .7. Interventions will be individualized and part of an overall care environment that supports physical, functional and psychosocial needs, and strives to understand, prevent or relieve the resident's distress or loss of abilities. 8. Interventions and approaches will be based on a detailed assessment of physical, psychological and behavioral symptoms and their underlying causes, as well as potential situational and environmental reasons for the behavior. The care plan will include, as a minimum .b. targeted and individualized interventions for the behavioral and/or psychosocial symptoms; c. the rationale for the interventions and approaches .e. how the staff will monitor for effectiveness of the interventions This citation relates to Complaint IN00454240. 3.1-43(a)(1)