Table 1: Deficiencies at F699 and Strategies to Prevent These Types of Deficiencies in Your Facility

Description of Deficiency	Considerations to Prevent Deficiencies
Lack of evidence of assessment of history of trauma (failure to assess whether or not residents had a personal history of trauma such as war trauma, sexual trauma, child abuse, etc.).	Facilities should work in collaboration with relevant stakeholders to review current processes by which residents are assessed for trauma. Assessment instruments are available to help with this process. Since these instruments may require training in the administration and interpretation of results, partnering with mental health professionals who are experienced in the assessment and treatment of trauma may be useful when it comes to screening high-risk individuals for histories of trauma. Assessment is never a "once and done" task. It often takes individuals time to develop sufficient levels of trust in those providing care to them before sharing histories of trauma, which are often steeped in shame and secrecy.
Lack of individualized assessment of "triggers" (that is, what factors "trigger" the resident to relive or re-experience the trauma).	When histories of trauma were identified, surveyors found a failure to assess "triggers" that could activate feelings of fear in the individual (re-experiencing). For instance, do loud noises activate memories of past trauma? Does the act of disrobing for a shower remind the individual of a sexual assault? Are certain scents in the facility associated with traumatic memories? New experiences in the facility could also "trigger" past trauma. For this reason, ongoing assessment of the resident's "triggers" should occur. While impossible to eliminate all trauma triggers, warning the resident of potential triggering situations can by itself be a useful intervention. Partnering with mental health professionals who are skilled in the assessment and treatment of trauma may also be useful in terms of developing strategies to address triggers.
Failure to develop a personalized plan of care for those with a history of trauma/lack of interventions designed to address trauma.	In facilities that identified a trauma history, surveyors found failure to develop individualized interventions to both treat existing trauma and prevent re-traumatization. Specifically, what individualized interventions could/should be used? What interventions are helpful? Realistic? In situations where facilities lack staff with knowledge of trauma treatment/care planning, consider partnering with mental health professionals to assist in developing individualized interventions to address trauma but also prevent re-traumatization.
Exclusive use of pharmacological interventions in the treatment of trauma/ administration of medication only (no evidence of non-pharmacological approaches).	Posttraumatic stress disorder is often treated with medications; however, many of these medications are either partially effective or ineffective.[15] Like psychotropic medications to treat other conditions such as depression or anxiety, the drugs used to treat PTSD (such as Paroxetine or "Paxil") can abruptly stop working- a phenomenon known as "poop out."[15] Because of this, psychotherapy is an essential part of treating trauma, and nonpharmacologic interventions are essential to preventing re-traumatization. When facilities lack staff with knowledge of trauma treatment/care planning, partner with local mental health professionals to assist in developing individualized interventions to address trauma but also prevent re-traumatization.
Staff were unaware of which residents had a history of trauma, what the triggers for the resident's trauma were, and what interventions to use to prevent re-traumatization.	Relevant care planned areas need to be communicated (as applicable and appropriate) to all care team members (ancillary departments, as appropriate) as well. Dietary, laundry, housekeeping, and maintenance personnel should be aware that their interaction with residents with a history of trauma has the potential to "trigger" the resident's trauma. Shift reports by the charge nurses, nursing supervisors, etc., may be a useful way to get all facility staff on the same page when it comes to preventing re-traumatization.
Inability to get timely visits with a psychologist.	Depending on the facility's location, there may not be any local psychologists, or if there are, they may not be willing to travel to your facility. Some therapists may leverage remote technology for this purpose. It is also important to determine if the ordering provider is ordering a psychologist consult for a very specific reason (for instance, neuropsychological testing, which can only be done by a licensed psychologist) or for the purposes of obtaining counseling services for the resident, which can be done (depending on state licensure and scope of practice) by a variety of mental health professionals such as licensed professional counselors, licensed clinical social workers, addictions counselors, and certified psychoanalysts. Clarification of the purpose of the consult can increase the potential pool of individuals who can see the resident and will provide the resident with more choice of who they would like to see for mental health care and services.