Severity Level 1: No actual harm with potential for minimal harm

The failure of the nursing home to provide appropriate care and services to a resident who is receiving dialysis care and services is more than minimal harm. Therefore, Severity Level 1 does not apply for this regulatory requirement.

F699

(Rev. 211; Issued: 02-03-23; Effective: 10-21-22; Implementation: 10-24-22)

§483.25(m) Trauma-informed care
The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.

INTENT
The intent of this requirement is to ensure that facilities deliver care and services which, in addition to meeting professional standards, are delivered using approaches which are culturally-competent and account for experiences and preferences, and address the needs of trauma survivors by minimizing triggers and/or re-traumatization.

DEFINITIONS
"Culture" is the conceptual system that structures the way people view the world—it is the particular set of beliefs, norms, and values that influence ideas about the nature of relationships, the way people live their lives, and the way people organize their world**.** Adopted from Substance Abuse and Mental Health Services Administration. Improving Cultural Competence.
Treatment Improvement Protocol (TIP) Series No. 59. HHS Publication No. (SMA) 14-4849.
https://store.samhsa.gov/system/files/sma14-4849.pdf**.**

"Cultural competency" is a developmental process in which individuals or institutions achieve increasing levels of awareness, knowledge, and skills along a cultural competence continuum. Cultural competence involves valuing diversity, conducting self-assessments, avoiding stereotypes, managing the dynamics of difference, acquiring and institutionalizing cultural knowledge, and adapting to diversity and cultural contexts in communities.

US Department of Health and Human Services publication: A Blueprint for Advancing and Sustaining CLAS Policy and Practice at:
https://thinkculturalhealth.hhs.gov/clas/blueprint#:~:text=A%20Blueprint%20for%20Advancing%20and%20Sustaining%20CLAS%20Policy,culturally%20and%20linguistically%20appropriate%20services%20within%20your%20organization .

"Trauma" results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and

that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being ("Trauma." SAMHSA-HRSA Center for Integrated Health Solutions. Substance Abuse and Mental Health Services Administration. 30 Nov 2016. Accessed at: https://www.samhsa.gov/resource/dbhis/samhsas-concept-trauma-guidance-trauma-informed-approach.

"Trauma-informed care" is an approach to delivering care that involves understanding, recognizing and responding to the effects of all types of trauma. A trauma-informed approach to care delivery recognizes the widespread impact and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures and practices to avoid re-traumatization. Referred to variably as "trauma-informed care" or "trauma-informed approach." Adapted from Concept of Trauma and Guidance for a Trauma-Informed Approach: https://store.samhsa.gov/system/files/sma14-4884.pdf

GUIDANCE: §483.25(m)

Background: Increasingly diverse demographics among nursing home residents require nursing homes to provide culturally competent care. Cultural competency, which includes language, and cultural preferences, and other cultural aspects such as thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups, is an important aspect of person-centered care. These elements influence the beliefs surrounding health, healing, wellness and the delivery of health services and are critical to reducing health disparities. "Cultural competence has emerged as an important issue for three practical reasons. First, as the United States becomes more diverse, practitioners will increasingly see people with a broad range of perspectives on health, often influenced by their social or cultural backgrounds. Second, research has shown that provider-patient communication is linked to health outcomes. [1] And third, two landmark Institute of Medicine (IOM) reports—Crossing the Quality Chasm and Unequal Treatment—highlight the importance of patient-centered care and cultural competence in improving quality and eliminating health disparities. [2]

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), seventy percent (70%) of adults in the United States have experienced some type of traumatic event, at least once in their lives. There is a direct correlation between trauma and physical health conditions such as diabetes, chronic obstructive pulmonary disease (COPD), heart disease, cancer, and high blood pressure.

While care and services must always be person-centered and honor residents' choice and preferences, what is different about providing care and services to a trauma survivor is that these residents may have lost the ability to trust caregivers, and to feel safe in their environment. As a result, the principles of trauma-informed care must be addressed and applied purposefully.

The following principles pertaining to trauma-informed care have been adapted from SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach, located at

https://store.samhsa.gov/system/files/sma14-4884.pdf

- Safety – Ensuring residents have a sense of emotional and physical safety.
- Trustworthiness and transparency – Efforts to establish a relationship based on trust, and clear and open communication between the staff and the resident.
- Peer support and mutual self-help – If practicable, it may be appropriate to assist the resident in locating and arranging to attend support groups which are organized by qualified professionals. It may be possible for the group to meet in the facility.
- Collaboration – There is an emphasis on partnering between a resident and/or his or her representative, and all staff and disciplines involved in the resident's care in developing the plan of care. There is recognition that healing happens in relationships and in the meaningful sharing of power and decision-making.
- Empowerment, voice, and choice – Ensuring that resident's choice and preferences are honored and that residents are empowered to be active participants in their care and decision-making, including recognition of, and building on resident's strengths.

Assessment

Facilities should use a multi-pronged approach to identifying a resident's history of trauma as well as his or her cultural preferences. This would include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event, as well as screening and assessment tools such as the Resident Assessment Instrument (RAI), Admission Assessment, the history and physical, the social history/assessment, and others. There are many psychosocial screening and assessment tools available including assessment tools from the United States Department of Veterans Affairs site PTSD: National Center for PTSD, https://www.ptsd.va.gov/professional/index.asp .

Trauma

Residents of long-term care facilities may include, but are not limited to, trauma survivors such as military veterans, survivors of large-scale natural and human-caused disasters, Holocaust survivors, survivors of physical, sexual, and/or mental abuse (past or current), or other violent crime, as well as residents with a history of imprisonment, homelessness, or who have suffered the traumatic loss of a loved one.

The history and physical assessment done by the attending physician can reveal many clues to a resident's history of trauma. Scars and other signs of physical trauma should be explored to determine the cause if the resident is comfortable/agreeable with discussing them. Numerical tattoos may be an indicator of World War II Holocaust survivors. Residents with a history of trauma may have diagnoses such as anxiety, depression, or may have substance abuse issues such as alcoholism, and/or may abuse prescription medications or street drugs. Evidence of physical and/or psychological trauma can be revealed during a comprehensive social history or assessment by the social worker.

Triggers

Facilities must identify triggers which may re-traumatize residents with a history of trauma. A trigger is a psychological stimulus that prompts recall of a previous traumatic event, even if the stimulus itself is not traumatic or frightening. For many trauma survivors, the transition to living in an institutional setting (and the associated loss of independence) can trigger profound re-traumatization. While most triggers are highly individualized, some common triggers may include:

- Experiencing a lack of privacy or confinement in a crowded or small space;
- Exposure to loud noises, or bright/flashing lights;
- Certain sights, such as objects that are associated with those that used to abuse, and/or
- Sounds, smells, and even physical touch.

Culture

As mentioned in the Background section above, the increasingly changing demographics of nursing homes has led to the need to provide culturally competent care. In addition to racial and ethnic diversity, this also includes religious preference, sexual orientation, and gender identity.

There are several tools that facilities may use in addition to the Resident Assessment Instrument (RAI) to assist them in identifying a resident's cultural preferences. Chapter 3 of the RAI gives guidance on completing Minimum Data Set (MDS) items in section A that addresses Race, Ethnicity, and Language with which the resident most closely identifies. These MDS items may be indicators of a resident's culture and may indicate further assessment is necessary to determine if there are any cultural preferences which should be honored while the resident is in the facility. The categories in this classification are socio-political constructs and should not be interpreted as being scientific or anthropological in nature. They provide demographic race/ethnicity specific health trend information. These categories are NOT used to determine eligibility for participation in any Federal program.

MDS Section A identifies whether the resident wants or needs an interpreter and the resident's preferred language. Inability to make needs known and to engage in social interaction because of a language barrier can result in isolation, depression, and unmet needs. Language barriers can interfere with accurate assessment.

Facilities must use their Facility Assessment (See F838 for additional guidance related to Facility Assessment) to identify resident populations having unique cultural characteristics, such as language (including American Sign Language), religious or cultural practices, values, and preferences. This facilitates a facility-wide and department-wide understanding of cultural differences and how to approach the provision of care and services with dignity and respect for the individual. (Also see, F675, Quality of Life, for further discussion of the impact of cultural differences on residents and staff.)

NOTE: Facilities are required to communicate effectively, both verbally and in writing, with residents in a language and manner they can understand. For additional information see F552, Right to be Informed/Make Treatment Decisions; F572, Notice of Rights and Rules; and F573, Right to Access/Purchase Copies of Records.

Cultural Competencies

Cultural competencies help staff communicate effectively with residents and their families and help provide care that is appropriate to the culture and the individual. Cultural competence (also known as cultural responsiveness, cultural awareness, and cultural sensitivity) refers to a person's ability to interact effectively with persons of cultures different from his/her own. With regard to health care, cultural competence is a set of behaviors and attitudes held by clinicians that allows them to communicate effectively with individuals of various cultural backgrounds and to plan for and provide care that is appropriate to the culture and to the individual.

The following resources are intended for informational purposes only:

- The National Center for Cultural Competence https://nccc.georgetown.edu
- The National Standards for Culturally and Linguistically appropriate Services in Health and Health Care (developed by the Office of Minority Health in HHS)https://www.thinkculturalhealth.hhs.gov/clas/blueprint
- Office of Minority Health "Think Cultural Health" website https://www.thinkculturalhealth.hhs.gov
- Georgetown University publication: Cultural Competence in Health Care: Is it important for people with chronic conditions https://hpi.georgetown.edu/agingsociety/pubhtml/cultural/cultural.html

Care Planning to Address Past Trauma

The facility should collaborate with resident trauma survivors, and as appropriate, the resident's family, friends, and any other health care professionals (such as psychologists, mental health professionals) to develop and implement individualized interventions. In some cases, if a facility has more than one trauma survivor, social services might consider establishing a support group that is run by a qualified professional, or allowing a support group to meet in the facility. In situations where a trauma survivor is reluctant to share his or her history, facilities are still responsible to try to identify triggers which may re-traumatize the resident, and develop care plan interventions which minimize or eliminate the effect of the trigger on the resident.

Trigger-specific interventions should identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident.

Examples of trigger-specific interventions include, but are not limited to the following:

Trigger	Intervention
Showers/shower fixtures	Provide alternative methods for bathing such as tubs, sponge bath.
Confinement in small/crowded spaces	Offer individual or small group activities
Loud noises	Decrease/eliminate exposure to loud noises during holiday celebrations (July 4th, New Year's Eve); and/or decrease volume of, or eliminate overhead paging systems
Removal of clothing	Consideration should be given to methods of assistance given to resident such as: • Consistent staffing/same-sex care giver • Removing clothing slowly • Explanation of what is happening
Exposure to smoke or fire	• Remove from areas where smoking is permitted, or cookouts occur; • Provide alternative meals inside facility

Additionally, trauma-specific interventions should recognize the interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, depression, and anxiety.

Trauma-specific interventions generally recognize the survivor's need to be respected, informed, connected, and hopeful regarding their own recovery. Trauma survivors may need access to support groups either in the facility or in the community, if appropriate and feasible.

Care Planning to address Cultural Preferences

When a facility admits a resident, it has determined that it can provide the individualized care and services that resident requires. Facilities must create and sustain an environment that humanizes and promotes each resident's well-being and feeling of self-worth and self-esteem. This requires nursing home leadership to establish a culture that treats each resident with respect and dignity as an individual, and addresses, supports and/or enhances his/her feelings of self-worth including personal control over choices and cultural preferences.

It is important for facilities to be aware of the impact of culture and cultural preferences on the provision of care and have an understanding of the cultural norms and practices of the individuals they care for. For example, in some cultures, it may be considered taboo to direct care at end of life; or in other cultures care must be provided by caregivers of the same sex as the resident.

In order to provide culturally competent care, staff must understand the cultural preferences of the individual and how it impacts the delivery of care. A key component is identifying how to communicate with the resident, in order to be able to identify physical concerns and issues, and for developing a trusting relationship with staff. For example, if the resident is non-English speaking, or has limited understanding of English, the facility should identify how communication will occur with the resident. The care plan should identify the language spoken and what tools are available to communicate, whether it be with a communication board or other systems, or through translators. If communication systems are used, all staff interacting with the resident must know where those materials are kept, must understand how to use them, and consistently implement use of those methods. Staff must demonstrate proficiency in communicating with the resident to assure that critical information can be conveyed, such as a change in condition, the presence of pain, explanation of routine care, and the ability to refuse care and services. The facility must provide sufficient guidance for staff, including temporary staff, on how to communicate and deliver care for the resident. See also §483.10(c)(1), Resident Rights and §483.21(b)(3)(iii) Comprehensive Person-Centered Care Planning.

There are many aspects of cultural preferences which may impact the delivery of care, such as:

- Food preparation and choices;
- Clothing preferences such as covering hair or exposed skin;
- Physical contact or provision of care by a person of the opposite sex; or
- Cultural etiquette, such as avoiding eye contact or not raising the voice.

Additionally, facilities should consider:

- Offering activities that are culturally relevant to resident populations within the facility;
- Group activities with both sexes may not be permitted or appropriate in some cultures, or the type of programming may be in conflict with his/her cultural preferences;
- Providing reading materials, movies, newspapers in the resident's preferred language may help orient a resident to date, times and events;
- Allowing the performance of religious rites at end of life to the extent possible; and
- Certain medications, procedures or treatments may be prohibited.

Social services and facility administration may need to evaluate how forms, including informed consent forms, are provided in the language used by the resident. As mentioned above, this is a facility-wide opportunity to provide a culturally diverse environment, respecting and treating each resident with dignity. Assisting the resident and his/her representative with daily schedules, developed with input by the resident/representative, ahead of time may alleviate fear and frustration.

Resident-specific approaches must be developed and included in the resident's care plan. These interventions must be provided consistently, and supervising staff should monitor the delivery of care and staff interactions with the resident to assure they are implemented as written. Using consistent staff, to the extent possible, will assist the resident in feeling more comfort in the facility. If concerns related to culturally competent and/or trauma-informed **care planning** are identified, see additional guidance at §483.21(b) in F656.

Monitoring Delivery of Care and Services

As required with any care plan interventions, facilities must monitor the effects of their approaches to ensure they are implemented as intended, and are having the desired effect to achieve the measurable objectives and the resident's goals for care. For residents with a history of trauma in particular, facilities must evaluate whether the interventions have been able to mitigate (or reduce) the impact of identified triggers on the resident that may cause re-traumatization. It is critical to involve the resident and/or his or her family or representative in this evaluation to ensure clear and open discussion and better understand if interventions must be modified.

It may be necessary to engage the services of an interpreter to monitor or evaluate the effect of cultural interventions for non-English speaking residents. As noted above, it is critical to involve the resident and/or his or her family in evaluating the effectiveness of cultural interventions in achieving measurable objectives and resident goals.

Surveyors should refer to the following when investigating concerns and citing noncompliance related to culturally-competent, trauma-informed care:

- F656: For concerns related to development or implementation of culturally competent and/or trauma-informed care plan interventions;
- F699: For concerns related to outcomes or potential outcomes to the resident related to culturally-competent and/or trauma-informed care;
- F726: For concerns related to the knowledge, competencies, or skill sets of nursing staff to provide care or services that are culturally competent and trauma-informed.
- F742: For concerns related to treatment and services for resident with history of trauma and/or history of post-traumatic stress disorder (PTSD)

KEY ELEMENTS OF NONCOMPLIANCE

To cite deficient practice at F699, the surveyor's investigation will generally show that the facility failed to do any one of the following:

- Identify cultural preferences of residents who are trauma survivors;
- Identify a resident's past history of trauma, and/or triggers which may cause re-traumatization;
- Consistently use approaches that are culturally competent and/or are trauma-informed

INVESTIGATIVE SUMMARY

Use the General Critical Element (CE) Pathway along with the above interpretive guideline when determining if the facility meets the requirements to provide culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.

DEFICIENCY CATEGORIZATION

An example of Severity Level 4 Noncompliance: Immediate Jeopardy to Resident Health or Safety includes, but is not limited to:
A resident was admitted with a history of sexual abuse by a male and a diagnosis of post-traumatic stress disorder. The resident requested only female staff provide perineal care due to her severe trauma. A male staff person answered the resident's call light for assistance to the bathroom and insisted on performing perineal care as he was the only staff member available at the time. She refused his assistance and began to get visibly upset and requested that a female staff member be called in. The resident stated that the male staff member insisted on performing perineal hygiene after she had toileted despite the residents past trauma. After returning her to her bed, she was crying and distraught and stated that she was afraid to request assistance with perineal care as he might return. She stated she cried all night and that she had profuse sweating, fearing that someone was outside her door, waiting to come in if she fell asleep. Eventually the resident fell asleep but awakened screaming, kicking and throwing objects, re-living her previous sexual assault. She told staff who came into her room that she was fearful for her life, felt dirty and demeaned, that she wasn't respected, and there was no reason to go on living.

An example of Severity Level 3 Noncompliance: Actual Harm that is not Immediate Jeopardy includes, but is not limited to:

Residents were gathered to watch July 4th fireworks on television. A resident with a known history of surviving a mass shooting several years ago was placed in the activity room to watch the fireworks. When the show began, the resident became tearful and frightened when he heard the sound of the fireworks which resembled the sound of gun shots. The facility staff noticed that the resident was tearful and appeared frightened. When asked what was wrong, the resident shared that he was having flashbacks from the mass shooting he survived years ago. The staff member rubbed the resident's back and said "it will be okay \\\\\, the show is only 30 minutes long." The resident remained in the activity room for the duration of the fireworks and continued to be tearful. In the following weeks, the resident decreased his attendance at activities that he previously enjoyed.

An example of Severity Level 2 Noncompliance: No Actual Harm with potential for more than minimal harm that is not Immediate Jeopardy includes, but is not limited to:

Facility staff escorted residents to a local baseball game. One of the residents was a survivor of a refugee camp and is not comfortable in highly populated areas. Prior to leaving for the game, facility staff failed to consider the resident's discomfort with crowded areas due to his time in a refugee camp. Upon arriving to the baseball game, there were hundreds of fans that came to watch the game. While watching the game, the resident informed one of the facility staff members that he was not enjoying himself because he was feeling anxious in the stadium with so many people around him and often has panic attacks when he is in crowded areas too long. The facility staff member immediately escorted the resident out of the stadium and onto the bus where his anxiety resolved.

An example of Severity Level 1 noncompliance: No actual harm with potential for minimal harm:

Because of the potential for psychosocial harm, noncompliance at F699 should generally not be cited at severity level 1.

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[1] Lurie, N., Jung, M., & Lavizzo-Mourey, R. (2005). Disparities and quality improvement: Federal policy levers. Health Affairs, 24(2), 354- 364.

[2] Betancourt, J. R., Green, A. R., Carillo, J. E., & Park, E. R. (2005). Cultural competence and health care disparities: Key perspectives and trends. Health Affairs, 24(2), 499-505.