| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E185 | A. Building<br>B. Wing | 11/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Bywood East Health Care | 3427 Central Avenue Northeast<br>Minneapolis, MN 55418 |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for 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** Based on observation, interview, and document review the facility failed to prevent and protect 3 of 3 residents (R1, R2, and R3) from physical and verbal abuse when staff failed to remove R2 and bystanders after R1 demonstrated aggression toward R2 which led to physical altercation between R1, R2, and R3. In addition, facility failed to comprehensively assess for triggering behavior patterns and implement interventions that could decrease the risk and/or prevent for recurrent incidences of resident-to-resident abuse. Findings include:R1's quarterly Minimum Data Set (MDS), dated [DATE], indicated intact cognition with diagnoses including type 2 diabetes, depression, and psychoactive substance abuse. R1 was independent with all activities of daily living (ADL). R1 had verbal behavioral symptoms directed at others 1-3 days and rejection of care 4-6 days during the assessment period.R1's care plan dated 8/28/25 indicated R1 had potential for behavior concerns related to verbal and physical aggression towards residents. Interventions included encourage R1 to remove himself from altercations before they escalate, encourage R1 to notify a staff member before verbal altercations escalate, try to find a resolution to R1's concerns rather than arguing, and when R1 is aggressive, give him space, attempt to redirect and notify Police. The care plan also indicated R1 had potential for abuse related to vulnerable adult status with goal of R1 will note be abused. Interventions included staff will follow facility vulnerable adult policy to keep resident safe from abuse.On 10/28/25, a video of a resident-to-resident altercation was reviewed in which the director of nursing (DON) stated R1 was the verbal aggressor and R2 was the physical aggressor. The video identified on 10/25/25 at 2:40 p.m. R2 and another resident were in the hallway outside R2's room talking (no audio on the video)-At 2:46 p.m. R1 opened the door to his room said something then closed door.-At 2:46:44 p.m. R2 walked to nurse's station where trained medication assistant (TMA)-A was standing; the two were facing each other with mouths moving.-At 2:46:53 p.m. R1 came out of his room. R2 walked towards R1, R2's mouth was moving, and her arms were at her side. R1 started waving his hands near R2's face. His fingers were observed pointing straight with his thumb tucked in. His hand was perpendicular with the floor, and he was shaking it up and down. It was unclear whether R1 contacted R2's face.-At 2:47:04 p.m. R2 swatted R1's hand out of her face. R1 walked towards TMA-A. R1 and R2's mouths continued to move. R1 continued to wave his hand in her face.-At 2:47:27 p.m. R2 slapped R1 in the face. The two backed away from each other as R1 looked towards TMA-A.-At 2:47:41 p.m. R2 pushed R1. He stepped back and TMA-A positioned herself between R1 and R2. TMA-A put her up arms in front of R2. R3 was standing in his doorway; DON stated R3 was asking R1 to leave R2 alone. R1 crossed the hallway to R3 and pushed him into another resident's room. They went out of video view. R2 went around TMA-A and ran towards R1. R2 then pulled on R1's shirt and kicked her leg towards R1.-At 2:48 p.m. fight continued. R3 and R1 had their arms locked together moving down the hallway. R1 went down on his knees then R3 started punching R1. R2's mouth was moving and appeared to be yelling. R1 and R3 were on the ground wrestling. R2 jumps on R1's back and starts hitting R1. R3 got to his feet and moved away from R1.-At 2:49:38 p.m. R1 walked away from R2 and R3. TMA-A kept them separate. R1 walked past TMA-A, R2 and R3 and<br>(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 |
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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | went into his room. TMA-A was talking to R2. R1 came out of his room then walked to the stairway. R2 and R3 went to their respective rooms.R2's admission MDS dated [DATE] indicated R2 did not have cognitive impairment and had diagnoses of post-traumatic stress disorder (PTSD) anxiety, depression, bipolar disorder, and schizophrenia. R2 was independent with all ADLsReview of R2's clinical record identified that although she was admitted to the facility with a documented history of trauma, including abuse and associated maladaptive psychological responses, there was no indication that the facility had conducted a comprehensive trauma-informed care assessment.R2's care plan dated 8/4/25 indicated R2 was a vulnerable adult related to mental illness with a goal of R2 will be provided with a safe environment and minimize risk of abuse. This focus area indicated on 6/6/25 R2 was in a verbal altercation on the back smoking patio; R2 threw water in other resident's face during altercation. Remind resident to walk away from disagreements with others and go sit in a quiet place and deescalate and notify staff. R2's care plan did not address and/or include a focus for management and treatment of PTSD that identified target behaviors/triggers with individualized goals of care and interventions to prevent and/or manage re-traumatization.R3's quarterly MDS dated [DATE] indicated intact cognition with diagnoses including schizoaffective disorder, bipolar type, depression and anxiety. R3 was independent with all ADL's R3 demonstrated physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) 4-6 days, Verbal behavioral symptoms directed towards others 1-3 days, reject evaluation or care 4-6 days. R3's care plan dated 7/30/25 indicated R3 had potential for abuse related to vulnerable adult status with goal of R3 will not be abused. Interventions included staff will follow facility vulnerable adult policy to keep resident safe from abuse.Review of R1's, R2's, and R3's records R1, R2 and R3's care plans were updated on 10/27/25. The focus was physically abusive behavior symptoms directed at others with interventions including house psychologist will visit with residents as needed, medications per doctor order, and resident was in physical altercation with peer. Encourage resident to stay away from peer. If altercation occurs staff to intervene and separate residents if able. Each care plan identified the peer the resident had the altercation with.During an interview on 10/29/25 at 9:38 a.m., R3 stated the afternoon of 10/25/25 he heard yelling outside his door. When he came out, he saw R2 with her back against the wall and R1 right in her face. R1 came at R3, grabbed his shirt and pushed him into another resident's room. During an interview on 10/28/25 at 2:09 p.m. R2 explained she had been abused most of her life by men and as a result I have PTSD. So, because of her experiences R2 exclaimed I deserve to feel safe! I will go after anyone who gets in my face!!!. R2 explained what happened when R1 kept pointing his fingers inches from her face (R2 demonstrated R1's proximity to her and the hand gestures he made) and made contact with her face. R2 pushed R1's hand out of her face and started to walk away, but R1 followed her and continued with the pointing and yelling. When R1 went after R3, R2 felt she needed to protect R3, so she ran after R1 to pull him off R3. R2 explained after the incident she looks out her window before leaving her room to see if R1's vehicle is parked outside because she doesn't want to take a chance of running into him. If she sees his car, her plan was to stay in her room. If she does run into him in the halls, she would try to ignore him. R2 stated she feels like a mouse in a cage with a snake. She is the mouse just waiting for the snake (R1) to up out and get her. During an interview on 10/28/25 at 2:51pm, TMA-A stated on 10/25/25 she heard shouting and saw R1 in the doorway to his room. R1 asked TMA-A to tell R2 to be quiet. TMA-A told R1 that R2 was speaking at a reasonable level and was allowed to have a conversation in the hallway. R1 went back into his room but came out again yelling and swearing. R1 was waving 4 fingers in R2's face and yelling at her. TMA-A asked R1 to stop and go back to his room, but he continued to shake his fingers near her face and yell. TMA-A did not ask R2 to go to her room or move away from the situation as R2's care plan directed. TMA-A stepped between R1 and R2 but R2 was still able to reach out and slap R1. TMA-A's explained R3's involvement as per the video. During the interactions TMA-A continued to try to de-escalate by asking the three residents to return to their rooms. The residents finally separated and went separate<br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | directions. I don't know what got into her [R2]. I've never seen her [R2] like that. TMA-A stated she has observed R2 yelling at other residents but had never seen R2 engage in a physical altercation. TMA-A did not know if R1 or R2 had any specific triggers for their behaviors. She would look in the care plan for any information related to the resident.A facility incident report for R1 dated 10/26/25 identified another physical altercation between R1 and R2 on 10/26/25. The report included- R2 continued to strike R1 while R2 shouted He hit me, He took my phone. R1's description of the incident included R2 came after him in the elevator and started punching him. R1 tried to hold R2's arms so she could not hurt him. A facility incident report for R2 dated 10/26/25 indicated a physical altercation occurred between R1 and R2. R2 continued to strike R1 while R2 shouted He hit me; He took my phone. R2's description of the incident included R1 put his hands on R2 and took her phone, so she had to defend herself.During review of the video of the 10/26/25 altercation, R2 was observed assisting a resident off the elevator. R1 was observed walking past R2 several times. No staff members were observed in the hallway. A resident was observed in the doorway of the elevator when R1 walked behind him and started pushing him into the elevator. R2 walked to the elevator, shoves R1 against the side of the elevator door then R1 punches R2 on the left side of her head. Staff ran into the elevator and separated R1 and R2. R2 swung her arms at R1. R1 walked out of the elevator and down the hall. Director of nursing (DON) confirmed R2 was struck in the head by R1.R2's general condition note dated 10/27/25 indicated R2 stated her face hurts where she was punched by R1 but there is no sign of swelling or bruising.R2's care plan was revised on 10/27/25 to include a behavior focus but did not include a focus for PTSD with associated triggers. The behavior care plan indicated R2 had physically abusive behavior symptoms directed toward others. Associated interventions included house psychologist will visit with resident as needed, medications her MD order, encourage R2 to stay away from R1, if altercation occurs staff to intervene and separate residents.R1 was not available for interview.During an interview on 10/28/2025 at 2:09 p.m. R2 stated on 10/26/25 she saw R1 shoving another resident's wheelchair into the elevator. When R2 went to intervene, R1 punched her in the head. R2 stated she shoved R1 to get to the other resident because she thought R1 was hurting the other resident. R2 had a bad headache after R1 had punched her in the side of her head on 10/26/25 and she was still experiencing some pain on the left side of her face.During an interview on 10/29/25 at 10:41 a.m., TMA-B stated if 2 residents were in a verbal altercation she would ask the agitated resident to go to their room or outside. After they have calmed down, she would talk to them to figure out what had upset them and try to fix it. Following the 2 incidents, R1 and R2 could not be in the same place without supervision. TMA-B would remind them not to be in the same room together without supervision.During an interview on 10/29/25 at 4:30 p.m., licensed practical nurse (LPN)-A stated behavior interventions were in each resident's care plan. R1 and R2 need to be kept separate. LPN-A would make sure she knew where R2 was because she would not want R1 and R2 to meet in the hallway. R2 listens to LPN-A so R2 would be easier to redirect to a different location.During an interview on 10/29/25 at 4:49 p.m., TMA-C stated if she heard a resident yelling at another resident, she would use the walkie-talkie to call for assistance then try to separate the residents by talking with them. She would ask the residents to go to their rooms or wherever they wanted to go that was away from each other.During an interview on 10/29/25 at 5:05 p.m., LPN-B stated if residents were fighting, staff need to try to separate them by trying to redirect them with words. R1 and R2 need to be kept separate from each other. R1 usually stays in his room and doesn't associate with the other residents. If R1 and R2 were in the same place, LPN-B would talk to them to keep them distracted. LPN-B thought triggers for R1 and R2 might be on the TAR but did not find any.On 10/30/25 at 1:45 p.m., director of nursing (DON) was interviewed and stated the facility needed to keep the residents safe by following the care plan. Staff should talk to the residents, ask them to go to their room or somewhere away from the situation and/or follow mental health clinic's recommendations. DON stated the root cause of the altercation was R1 escalated R2. DON indicated after the incidents R2 informed her she had PTSD which is why she reacted so fast to R1. Staff were<br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | educated on 10/27/25 to encourage the 3 residents in the altercation to give space to each other and stay away from each other. Staff were to immediately intervene and separate if signs of verbal or physical altercation occurred. Staff were to encourage all residents to keep distance from peers and remind residents not to touch others. If a physical altercation happens, call the police.The facility Vulnerable Adult Abuse Prevention Policy revised 10/1 indicated the facility does not tolerate any forms of physical abuse by anyone. Physical abuse includes but is not limited to hitting, slapping, pinching and kicking. |

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| F 0699<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide care or services that was trauma informed and/or culturally competent.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to provide trauma informed care including failure to complete a comprehensive assessment that identified triggers in order to eliminate or mitigate the risk of re-traumatization for 1 of 1 resident (R2) who had a known history of trauma prior to admission. The facility's failures resulted in actual psychosocial harm for R2 when R2 was involved in two resident to resident abuse incidents that caused R2 ongoing fear and aggressive reactions that were uncharacteristic of R2. Findings includeR2's hospital functional assessment dated [DATE] indicated R2 reported significant history of trauma including abuse which have led to intrusive memories/thoughts, nightmares, dissociative reactions, and significant psychological stress.R2's admission Minimum Data Set (MDS) dated [DATE] identified R2 did not have cognitive impairment, did not have behaviors, and was independent with activities of daily living (ADL). R2 had diagnoses that included post-traumatic stress disorder (PTSD), anxiety, depression, bipolar disorder, and schizophrenia. Only CAA triggered was psychotropic drug use. Review of R2's clinical record identified that although she was admitted to the facility with a documented history of trauma, including abuse and associated maladaptive psychological responses, there was no indication that the facility had conducted a comprehensive trauma-informed care assessment. Specifically, the record lacked documentation identifying environmental and interpersonal triggers that could elicit a PTSD response, as well as personalized therapeutic goals, targeted trauma-informed interventions, and preventive practices designed to minimize re-traumatization and promote psychological safety.R2's care plan dated 8/4/25 indicated R2 was a vulnerable adult related to mental illness with a goal of R2 will be provided with a safe environment and minimize risk of abuse. This focus area indicated on 6/6/25 R2 was in a verbal altercation on the back smoking patio; R2 threw water in other resident's face during altercation. Remind resident to walk away from disagreements with others and go sit in a quiet place and deescalate and notify staff. R2's care plan did not address and/or include a focus for management and treatment of PTSD that identified target behaviors/triggers with individualized goals of care and interventions to prevent and/or manage re-traumatization.R2's Associated Clinic of Psychiatry (ACP) notes dated 9/10/25, 9/17/25, and 10/01/25 identified diagnosis of PTSD; although the notes included supportive behavioral interventions there was no indication R2's care plan was updated to include the recommendations; however, the notes did not address potentially distressing stimuli or individualized strategies to manage or prevent re-traumatization. The notes included: -R2's ACP visit note dated 9/10/25 included R2 has experienced extensive emotional, physical and verbal abuse throughout her life. R2 was a bleeding heart for other people. Treatment recommendations: R2 may benefit from emotional validation and normalization of grief symptoms. Benefits from spending time with friend in facility, sleeping and walking outdoors.-R2's ACP visit note dated 9/17/25 included R2 was able to articulate that a structured daily routine with group meetings was helpful to her. She values connections with others in a similar situation. Treatment recommendations: R2 was encouraged to care for herself by separating from the constant responsibility she feels with other peers in the building. R2 will continue to benefit from staff support, kindness, patience, and reminders that she is well-liked, appreciated and respected.-R2's ACP visit note dated 10/1/25 included R2 presents as spiraling into manic phase with increased irritability, pacing and impatience. The treatment recommendations included utilize de-escalation strategies including anticipate trigger events.R2's quarterly MDS dated [DATE] indicated intact cognition with diagnoses including PTSD and schizoaffective disorder, bipolar type. R2 had verbal behavioral symptoms directed towards others 4-6 days and rejection of care 1-3 days. Despite the increase in verbal behaviors since the previous assessment dated [DATE], there was no indication a comprehensive assessment was completed. Facility resident to resident incident reports and surveillance videos identified two altercations involving R2; one on 10/25/25 and the other on 10/26/25. Video on 10/25/25 at 2:46 p.m.<br>(continued on next page) |

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| F 0699<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | identified R1 exited his room as R2 walked toward him, speaking. R1 began waving his hand near R2's face in a rigid, vertical motion. It was unclear if contact was made. R2 swatted his hand away, and R1 moved toward TMA-A while continuing to gesture and speak. R2 then slapped R1 in the face, and both backed away. Moments later, R2 pushed R1, prompting TMA-A to intervene. R3 appeared and was reportedly asking R1 to leave R2 alone. R1 then pushed R3 into another room, out of view. R2 ran after R1, pulling his shirt and kicking at him. The situation escalated as R1 and R3 locked arms and moved down the hallway. R1 fell to his knees, and R3 began punching him. R2 appeared to yell and then jumped on R1's back, hitting him. R3 disengaged and moved away. R1 walked away from R2 and R3. TMA-A kept the residents separated.Video of the 10/26/25 altercation, R2 was observed assisting a resident off the elevator. R1 was observed walking past R2 several times. No staff members were observed in the hallway. A resident was observed in the doorway of the elevator when R1 walked behind him and started pushing him into the elevator. R2 walked to the elevator, shoves R1 against the side of the elevator door then R1 punches R2 on the left side of her head. Staff ran into the elevator and separated R1 and R2. R2 swung her arms at R1. R1 walked out of the elevator and down the hall. Director of nursing (DON) confirmed R2 was struck in the head by R1.R2's Behavioral Assessment for Physical Altercation dated 10/27/25 that was located in the download section of the electronic medical record on 10/28/25 at 2:05 p.m. was blank with no documentation. However, a subsequent assessment dated [DATE] that was completed with a notation This report was re-written due to error in saving the original written on 10/27/25 and was electronically signed on 10/30/25. This assessment summarized the abuse events, indicated no environmental triggers, the care plan was followed and was modified to prevent reoccurrence. The assessment identified the elements of the care plan that were not followed included Staff should encourage [R2] to remember that she is the more mature and bigger person. [R2] is vulnerable to [sic] Section 2: Behavioral Triggers and Context- included No prior triggers identified and R2 identifies as a survivor of domestic abuse and may be triggered by behavior that reminds her of past trauma. Males that suddenly invade personal space, provoke her verbally and when she cannot find her phone may trigger her react impulsively. Trigger identification checked was Personal space violation, Verbal provocation, and unable to locate phone. R2's record was reviewed between 10/25/25 through 10/30/25 at 2:05 p.m., although R2 had been involved in two resident-to-resident altercations, there was no indication a trauma assessment had completed. R2's care plan was revised on 10/27/25 to include a behavior focus but did not include a focus for PTSD with associated triggers. The behavior care plan indicated R2 had physically abusive behavior symptoms directed toward others. Associated interventions included house psychologist will visit with resident as needed, medications her MD order, encourage R2 to stay away from R1, if altercation occurs staff to intervene and separate residents.During an interview on 10/30/25 at 10:26 a.m., licensed social worker (LSW)-A indicated after the physical altercations he reviewed the videos and interviewed R2. LSW-A explained a behavioral assessment was supposed to be completed after a physical altercation and with any new admissions with a history of physical violence. The behavioral assessment includes asking about potential triggers; LSW-A stated he completed R2's assessment after the altercation but did not identify the date and time it was completed. LSW-A did not know if there was a formal trauma assessment the facility utilized, and he was not completing a trauma assessment on paper. Any information obtained by ACP would be entered into the care plan by interdisciplinary (IDT) team. LSW-A was surprised R2 lashed out at R1. She had never attacked anyone before. LSW-A did not know what triggered R2 to respond with aggression but thought R2 might have seen R1 waving his hands in her face as an attack or a precursor to an attack. LSW-A stated PTSD was caused by a serious event and domestic assault could be considered a PTSD event.During an interview on 10/28/25 at 2:09 p.m. R2 explained she had been abused most of her life by men and as a result I have PTSD. So, because of her experiences R2 exclaimed I deserve to feel safe! I will go after anyone who gets in my face! R2 explained what happened when R1 kept pointing his fingers inches from her face (R2 demonstrated R1's proximity to<br>(continued on next page) |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0699<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | her and the hand gestures he made) and made contact with her face. R2 pushed R1's hand out of her face and started to walk away, but R1 followed her and continued with the pointing and yelling. When R1 went after R3, R2 felt she needed to protect R3 so she ran after R1 to pull him off of R3. Now R2 looked out her window before leaving her room to see if R1's vehicle was parked outside because she did not want to take a chance of running into him. If she were to see his car, her plan was to just stay in her room. If she did run into him in the halls, she would try to ignore him. R2 stated she feels like a mouse in a cage with a snake. She is the mouse just waiting for the snake (R1) get her.During an interview on 10/29/25 at 9:38 a.m., R3 stated he heard yelling outside his door. When he came out, he saw R2 with her back against the wall and R1 right in her face. R1 came at R3, grabbed his shirt and pushed him into another resident's room.During an interview on 10/29/25 at 12:47 p.m., licensed mental health therapist (Th)-A stated she was familiar with R2; R2 would only participate in sessions when she was struggling with depression. Since the incidents on 10/25/25 and 10/26/25, R2 had been offered an evaluation however, R2 had declined so Th-A was not aware of the impact to R2's mental health. Th-A indicated someone who had PTSD is not always aware of what their real triggers are and their response to those triggers would also be very individualized. It was important to address a person's triggers to offer sensitivity and to know how a person might respond in a certain situation, however R2's triggers had not been evaluated or establishedOn 10/31/25 at 11:21 a.m., the medical director (MD) was interviewed and stated people with a past trauma often do not feel safe or secure. They might be less likely to trust anyone. Each person reacts to a traumatic event differently. Staff should attempt to address specific triggers especially if there was a chronic trauma. MD could not confirm if trauma assessments were being completed. MD stated even a person without PTSD might be triggered by someone yelling and waving fingers close to the face. Asking the person being yelled at to move away from the situation would be a reasonable request in that situation.During an interview on 10/30/25 at 1:45 p.m., director of nursing (DON) stated the facility did not have a formal trauma assessment nor an official care plan focus for trauma informed care. Any behaviors, trauma, or triggers would be in the psychosocial or vulnerable adult care plan focus. Behavior interventions were put in the care plan LSW-A. DON stated the root cause of the altercation was R1 escalated R2. DON indicated after the incidents R2 informed her she had PTSD which is why she reacted so fast to R1. DON had previously indicated he did not like anyone talking in the hallway. After the incident staff were provided education to move residents away from R1's doorway however, that was not in his care plan and to keep R1 and R2 separated.During an interview on 10/30/25 at 4:42 p.m., administrator confirmed trauma assessments were not being completed on the residents.The Quality of Care and Trauma Informed Care policy dated 9/2022 instructed residents who are diagnosed with a mental disorder, psychosocial adjustment difficulty and/or PTSD will be provided with appropriate treatment and services to attain the highest practicable level of mental and psychosocial well-being. Residents will be screened and assessed upon admission, quarterly and/or significant change by our social service department in order to identify any history of trauma and/or PTSD. The interdisciplinary team will document and care plan for any areas of trauma. This will include potential or actual triggers that may cause re-traumatization of the resident, experiences, preferences and/or other interventions that eliminate or mitigate triggers that cause re-traumatization of the resident, and identification of the stressor or past life trauma. |