STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465049	A. Building B. Wing	03/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Creek Healthcare Center	4600 South Highland Drive Salt Lake City, UT 84117

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review it was determined, for 1 out of 3 sampled residents, that the facility did not ensure that the resident had the right to be free from abuse. Specifically, a resident was physically abused when a Certified Nurse Assistant (CNA) hit and grabbed a resident forcefully. This incident resulted in the resident sustaining a bruise and a skin tear. Resident Identifier: 1. Findings included: Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included hemiplegia and hemiparesis, aphasia, dysphagia, chronic kidney disease, hyperlipidemia, benign prostatic hyperplasia, dorsalgia, spinal stenosis, and gastrostomy status. On 3/13/23 resident 1's medical records were reviewed. Review of resident 1's progress notes revealed the following: a. On 2/7/23 at 9:45 PM, the note documented that resident 1 returned from the local hospital. Resident 1 was resting in bed with eyes closed. b. On 2/8/2023 at 12:43 PM, the note documented by the Director of Nursing (DON) documented, Summary from night shift 2/7/2023 1900 [7:00 PM]: Aide spoke to DON and informed her of what was witnessed, aide also notified nurse and described what he had seen, a 2nd aide who was also in the room informed of what she heard while giving cares to the roommate. When writer walked in, she saw a tearful resident. An assessment by a second nurse was done to resident and skin tear to right forearm was observed, some discoloration to neck and a hematoma to left forearm. MD [Medical Doctor] notified, and appropriate personal. CNA was removed from the floor immediately following report. Residents' daughter and house physician were notified. Res [resident] transferred to [local hospital name] for further evaluation. c. On 2/9/23 at 9:34 AM, the Resident Advocate (RA) documented, Daily update: Resident was awake in bed. Stated he had a good night, SS [social service] gave him water, and talked about his Farsi language. Resident appeared to be in a good mood. (continued on next page)

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
	465049	A. Building B. Wing	03/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Creek Healthcare Center	4600 South Highland Drive Salt Lake City, UT 84117

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	d. On 2/10/23 at 4:16 PM, the RA documented, Daily update: Resident was awake in bed. Stated he good thus far. Resident wanted to sleep and get some rest. e. On 2/13/23 at 10:20 AM, the RA documented, Daily Note: RA assisted resident with some water. Resident said weekend was good. Expressed no concerns at this time. f. On 2/14/23 at 8:51 AM, the RA documented, RA asked resident how he is even was [sic] Resident appeared to be calm said all is ok. g. On 2/17/23 at 5:16 PM, the RA documented, Daily Note: Resident appeared to be in good spirits. Wife was visiting, expressed no concerns at this time. On 2/7/23 at 6:46 PM, resident 1's incident report documented Physical Abuse. The resident description documented that the resident was tearful and crying, demonstrating hitting motions. The report documented the injuries as a hematoma on the left elbow and a skin tear on the right antecubital. The report documented injury location of neck front also, with no description of that injury. The level of pain was documented as a 4 on the PAINAD score. The PAINAD scale scored the resident as follows: 2 points for Repeated Troubled Calling Out. Loud Moaning or Groaning. Crying. for negative vocalization; 1 point for Sad, Frightened, Frown facial expressions; and 1 point for Distracted or Reassured by Voice or Touch for consolability. The report documented that resident 1 was alert and oriented to self. On 3/7/22 at 7:47 PM, the hospital History & Physical (H & P) documented that resident 1 was seen after being assaulted by another resident at his care facility. Apparently, someone injured his right arm. He has a couple of small skin tears. The physical exam documented, Small skin tear on right upper elbow. No obvious deformity. Able to move arm through range of motion. A little bruising along the upper arm. The emergency room (ER) documented that an x-ray of the right humerus was obtained and the results did not indicate any fracture or dislocation. On 12/23/22, resident 1's Quarterly Minimum Data Set (MDS) documented no to should a Brief Interview for Mental Status (BIMS) assessment be conducted due to the resident was rarely/never understood. The assessment documented that the resident did not have any hallucinations or delusions. A depression screening assessment (PHQ-9) was not completed due to resident was rarely/never understood. Resident 1 was assessed as requiring 2-person extensive assistance for bed mobility, transfers, locomotion on the unit, dressing, and toilet use. Resident 1 was assessed as requiring one person extensive assist for locomotion off the unit, eating, and personal hygiene. On 2/7/23 at 8:14 PM, the facility submitted an initial entity report to the State Agency (SA). The report documented an incident of physical abuse to resident 1 by CNA 1 on 2/7/23 at 6:15 PM. The report documented CNA 2 and CNA 3 were witnesses to the incident and that CNA 1 allegedly hit resident 1 on the left arm. The report documented, Resident has redness on skin around on his chest. There is not clear evidence what caused the redness. Resident sent to [local hospital] for evaluation. The report documented changes in resident 1's behavior as being tearful. The report documented that CNA 1 was sent home and then terminated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465049	A. Building B. Wing	03/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Creek Healthcare Center	4600 South Highland Drive Salt Lake City, UT 84117

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	On 2/14/23 at 11:10 PM, the facility submitted to the SA the final 5 day investigation report. On 2/7/23 at 6:46 PM, the report documented that the Administrator (ADM) interviewed CNA 3. CNA 3 stated that she had witnessed CNA 1 hit resident 1 on the arm. The report documented that CNA 1 then advised resident 1 that it was ok to cry. CNA 3 stated that she knew what CNA 1 was doing was wrong and she immediately left to go grab the DON. On 2/7/23 at 6:50 PM, the ADM interviewed CNA 2. CNA 2 stated that she was treating resident 1's roommate but did not see CNA 1 hit resident 1. CNA 2 stated that she did hear CNA 1 tell the resident that it was ok to cry. The report documented the corrective action taken as termination of CNA 1 with the instructions to not return to the facility grounds. Review of the facility Abuse Policy documented, Residents must not be subjected to abuse by anyone, including but not limited to facility staff, The policy further defined physical abuse as including hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment and willful neglect of the resident's basic needs. The policy identified interventions of preventing abuse that included encouraging staff to talk with supervisors, department heads, Social Services, or the Administrator about residents or situations they found difficult to manage, stressful or frustrating. The policy documented that employees who were suspected of abuse were to be placed on immediate suspension while the matter was under investigation, and in the event that the investigation concluded abuse did occur, appropriate disciplinary action would be taken. This policy was last revised on 10/28/2020. On 3/13/23 at 10:40 AM, an observation was made of resident 1. The resident was sleeping in bed and appeared comfortable. The resident was observed wearing a baseball cap and sunglasses in bed. The resident was covered up to the torso with a sheet. The bed was in the low position and a fall mat was located on the left side of the bed. On 3/13/23 at 11:23 AM, an interview was conducted with resident 1's spouse at the bedside. The spouse stated that resident 1 had a stroke three years ago. The spouse stated that resident 1 could speak Farsi. The spouse was observed to converse with resident 1 and resident 1 was able to respond to questions in Farsi. The spouse stated that she loved the staff and the DON was the best manager. The spouse stated, Everybody loved her husband. The spouse stated that resident 1 had paralysis in the left arm, and too much pain with any movement. The spouse stated that she came to the facility Monday through Friday, and the DON notified her on the weekend on how resident 1 was doing. The spouse stated that resident 1 was not able to use the telephone so she would call to check up on resident 1. The spouse stated that resident 1 loved everyone, and no one had been unkind to him. Everybody is very nice. The spouse stated that the facility staff treated resident 1 like family. The spouse stated that resident 1 went to the hospital, after he was positioned with toileting, and it caused him pain. The spouse stated that staff needed to be gentler with positioning, and any movement and positioning caused resident 1 back pain. The spouse asked resident 1 if the staff treated him well. Resident 1 responded yes; they loved him. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465049	A. Building B. Wing	03/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Creek Healthcare Center	4600 South Highland Drive Salt Lake City, UT 84117

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	On 3/13/23 at 11:41 AM, an interview was conducted with the Social Service Worker (SSW). The SSW stated that the incident between CNA 1 and resident 1 happened over the weekend. The SSW stated that resident 1's spouse told her that a CNA had hit him and had cause a scratch on his arm. The SSW stated that the spouse told her that the ADM was taking care of it. The SSW stated that she was not sure about the injuries, and she was not directly involved in the investigation. The SSW stated that she started doing daily rounds after the incident to see how the resident was doing. The SSW stated that resident 1 did not have good English; he does a lot of pointing. The SSW stated that resident 1 knew Farsi and Arabic, and that she could converse with him in Arabic. The SSW stated that resident 1 could nod his head yes/no, and was able to make his basic needs known with hand gestures and yes/no questions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465049	A. Building B. Wing	03/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Creek Healthcare Center	4600 South Highland Drive Salt Lake City, UT 84117

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	On 3/13/23 at 12:30 PM, an interview was conducted with the DON. The DON stated that she came into the facility on the afternoon of the incident with resident 1 and CNA 1. The DON stated that it occurred shortly after or during shift change. The DON stated that one of the afternoon CNAs came and reported that resident 1 was crying. The DON stated that CNA 3 stated that she was helping resident 1's roommate and heard resident 1 crying. The DON stated that CNA 3 had reported that CNA 1 was helping resident 1 change his incontinence brief and he was crying. The DON stated that CNA 3 stopped feeding her resident and came around the privacy curtain to see what was going on. The DON stated that CNA 3 witnessed CNA 1 hitting resident 1's arm, and demonstrated with a closed fist striking motion. The DON stated that she went straight to resident 1's room and CNA 1 had already exited. The DON stated that she asked CNA 1 to come to the office, and then told her what was happening. The DON stated that she told CNA 1 that CNA 3 had witnessed her doing a striking motion to resident 1. The DON stated that CNA 1 denied it and said she would never do that. The DON stated CNA 2 was also present, but only heard resident 1 crying and did not see anything. The DON stated she asked CNA 1 what happened in resident 1's room, why was he crying, and she replied oh he always cries. The DON stated that CNA 1 denied hitting resident 1. The DON stated that she was not aware of resident 1 crying a lot. The DON stated that he would call out for his wife if she had not come in. The DON stated that when she went into resident 1's room to get CNA 1, resident 1 was still crying. The DON stated that she asked resident 1 if he was okay and he replied, the girl and did a striking motion and he was very upset. The DON stated that she assessed resident 1 and he had a new bruise starting to form on his right forearm with a small skin tear. The DON stated that the wound was bleeding a small amount. The DON stated that she did not perform any other skin assessment. The DON stated she did not ask if he was struck anyplace else and he did not say. The DON stated that resident 1's arms were red, but the right was more than the left. The DON stated that Licensed Practical Nurse (LPN) 1 transferred resident 1 to the local hospital for an evaluation. The DON stated that the nurse should have performed a head-to-toe skin assessment after an allegation of physical abuse, and it would be documented in a progress note. The DON stated that the process with allegations of abuse was they were to remove the alleged perpetrator and then notify the ADM. The DON stated that she notified the ADM right away. The DON stated that the ADM called the police, and LPN 1 notified the MD and the family. The DON stated that resident 1 returned from the ER that day, and no other findings were determined. The DON stated that she spoke to the spouse afterwards, and the spouse said with broken English that it was very sad, but resident 1 was okay. The DON stated that after she informed the ADM, she was not involved in any of the investigation. The DON stated that abuse training was done upon hire and then again during the in-services periodically. The DON stated that during the abuse training they go over the process, different types of abuse, notification, and any information that was needed. The DON stated that the process was if you witness or are made aware of an incident of abuse, you were to stop it, make sure the resident was safe, notify the nurse, and notify the DON and ADM. The DON stated that the licensed nurse should do the incident report, skin assessment, notification to the MD and DON, and notification to the ADM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465049	A. Building B. Wing	03/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Creek Healthcare Center	4600 South Highland Drive Salt Lake City, UT 84117

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	On 3/13/23 at 1:49 PM, a interview was conducted with CNA 2 with English/Spanish translator assistance provided by the Admissions Director (AD). CNA 2 stated that she was in resident 1's room assisting the roommate at the time CNA 1 was providing incontinence care to resident 1. CNA 2 stated that she heard resident 1 scream and cry. CNA 2 stated that this screaming and crying was not normal for him. CNA 2 stated that resident 1 normally cried a bit with repositioning, normally a little bit of complaining but this time it was screaming. CNA 2 stated that when she heard the crying she was with CNA 3. CNA 2 stated that CNA 3 went to check on resident 1 and witnessed CNA 1 hitting the resident. CNA 2 stated she stayed with the roommate and CNA 3 went to inform the nurse and DON. CNA 2 stated that resident 1 was crying a lot, and he had blood on his left arm in the antecubital area. CNA 2 stated that within a few minutes the DON came into the room. CNA 2 stated that resident 1 told the DON that CNA 1 had punched him, and he was worried and scared. CNA 2 stated that she had never seen CNA 1 be mean or hurt any residents before. CNA 2 stated that this was the first time she had worked with CNA 1. CNA 2 stated that the DON and ADM stayed with the resident, and she left the room. CNA 2 stated that she could not understand resident 1, but that she communicated with him using gestures and pictures. CNA 2 stated that resident 1 spoke some English and was able to communicate a bit. On 3/13/23 at 2:19 PM, an interview was conducted with CNA 3 with English/Spanish translator assistance provided by the AD. CNA 3 stated she was helping CNA 2 with resident 1's roommate, and she heard resident 1 crying a lot. CNA 3 stated that she went to look around the privacy curtain and witnessed CNA 1 grabbing resident 1. Resident 1 was crying, and CNA 3 stated she heard CNA 1 say, that's fine if you cry. CNA 3 stated that she saw CNA 1 push and grab resident 1's arm. It should be noted that the CNA demonstrated this motion in a forceful way. CNA 3 stated that resident 1 could not move the left side but he was attempting to push CNA 1 away with the right arm. CNA 3 stated that CNA 1 was really upset and was punching resident 1. CNA 3 stated that she went and stopped CNA 1 because she was being too rough with resident 1. CNA 3 stated that CNA 1 had positioned resident 1 in a flat position for the incontinence care. CNA 3 stated that she told CNA 1 that he was positioned wrong and that she needed to call the nurse to stop the tube feed first before positioning him flat. CNA 3 stated that CNA 1 said just leave me alone, this was the way I always do it. CNA 3 stated that she then left to report the incident. CNA 3 stated that she reported it to the DON, and then the DON called the ADM. CNA 3 stated that resident 1 was very difficult to speak with, and what she heard was him screaming. CNA 3 stated that she witnessed CNA 1 hit and then grab resident 1's right arm and then she turned him, she turned him on the right side towards the wall. CNA 3 stated that CNA 1 grabbed resident 1's arm closer to the antecubital. CNA 3 stated that the force the CNA 1 used was hard. CNA 3 stated that resident 1 could not do much other than scream and cry. CNA 3 stated resident 1 tried to defend himself with the right arm but that was when CNA 1 grabbed his arm forcefully. CNA 3 stated that she first heard CNA 1 say it's okay if you cry in English. CNA 3 stated that she could understand English, but she also confirmed this statement with CNA 2. CNA 3 stated that CNA 1 was upset and was acting nervous. CNA 3 stated that CNA 1 was agitated before she went in to help resident 1. CNA 3 stated that this occurred between 5:30 PM and 6:00 PM, because they were assisting the roommate with dinner. CNA 3 stated that she also informed LPN 1 and she took pictures of the wounds, and cleaned them. CNA 3 stated that when CNA 1 grabbed resident 1 she caused a skin tear. CNA 3 stated that when she noticed resident 1 was bleeding, she cleaned the blood and then notified the nurse, and the nurse cleaned the wound. CNA 3 stated that she did this because resident 1 was asking for help. CNA 3 stated that resident 1 showed her the wound while reaching for her. CNA 3 stated when the DON arrived resident 1 started crying more because he felt more comfortable and then he showed the DON what CNA 1 did to him. CNA 3 stated that she had not worked with CNA 1 prior to this. CNA 3 stated that they had never worked together but had worked the same shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465049	A. Building B. Wing	03/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Creek Healthcare Center	4600 South Highland Drive Salt Lake City, UT 84117

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	On 3/13/23 at 2:59 PM, an interview was conducted with the ADM. The ADM stated that he was driving nearby when he was informed of the incident by the DON. The ADM stated that the DON reported that CNA 3 had witnessed an incident between CNA 1 and resident 1. The incident was that CNA 1 was hitting resident 1's arm and was telling him that it was okay to cry. The ADM stated that when he talked to resident 1 and the family, they were not able to state why CNA 1 had said that. The ADM stated that he had the impression that CNA 1 was trying to help him, and he was yelling out and she was saying its okay. The ADM stated that he came right to the building and the DON had excused CNA 1 from the building. The ADM stated that LPN 1 did the bulk of the physical assessment for resident 1. The ADM stated that LPN 1 reported that resident 1 had some new injuries and pain in his arm, left arm I think. The ADM stated that resident 1 was sent to the hospital for a complete workup. The ADM stated that before resident 1 was sent out he spoke with the spouse, and she requested that he speak with the daughter. The ADM stated with the phone on speaker, he spoke with the resident and the daughter who was translating. The ADM stated that resident 1 reported that CNA 1 hit his arm, and he was crying throughout the conversation. The ADM stated that resident 1 demonstrated with the good arm a open hand hit. The ADM stated that resident 1 reported that this hurt his arm. The ADM stated that resident 1 was difficult to understand due to the crying and aphasia. The ADM stated that resident 1 was tearful and talking loudly. The ADM stated that resident 1 sometimes cried out during repositioning but was never tearful. The ADM stated that afterwards he interviewed all the residents on that section to see if they had been exposed to any abuse, and no one reported any other abuse. The ADM stated that afterwards he contacted the Police Department. The ADM stated that he spoke to CNA 1 a week later, and CNA 1 was concerned about her paycheck. The ADM stated that CNA 1 was notified that she was not allowed back to the property. The ADM stated that CNA 1 told him that she understood what had happened, and she was told that they could not tolerate that type of behavior. The ADM stated that CNA 1 was suspended immediately and then terminated within a couple of days. The ADM stated that the DON walked the aide out of the building at the time of the incident. The ADM stated that CNA 1 denied the incident and had tried to accuse the other aides of sabotaging her. The ADM stated that CNA 1 had said that they had a disagreement, and that they were ganging up on her and were trying to get her in trouble. The ADM stated that this was not plausible. The ADM stated that he interviewed CNA 3, she was consistent with the recollections, with the holding of the arm, she did the motion of hitting the arm, and reported the aide saying its okay to cry. The ADM stated that CNA 2 reported that she did not see anything, but she heard the resident crying and heard the aide say its okay to cry. The ADM stated that there were no prior reports of conflict between CNA 1, CNA 2, and CNA 3. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465049	A. Building B. Wing	03/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Creek Healthcare Center	4600 South Highland Drive Salt Lake City, UT 84117

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	On 3/13/23 at 4:50 PM, a telephone interview was conducted with LPN 1. LPN 1 stated that she was coming on shift, and one of the aides came to tell her that they were looking for the DON. LPN 1 stated that the DON asked her to go in and do an assessment on resident 1. LPN 1 stated that the aides told her that they were in the room and that CNA 1 was holding resident 1 too tightly, in a hurtful way while changing him, and he was getting upset. LPN 1 stated that CNA 3 notified her, while CNA 2 remained with resident 1. LPN 1 stated that at the time of the incident CNA 2 and CNA 3 were in the room feeding the roommate. LPN 1 stated that CNA 3 reported that CNA 1 was pushing resident 1's arm down and away in an aggressive way, grabbing it, pushing it, and holding it tightly. LPN 1 stated that she took a picture of resident 1's arm, notified the doctor, and wrote the report. LPN 1 stated she asked resident 1 if it hurt, and he was holding onto the right arm and crying. LPN 1 stated that the picture was of the right arm and showed discoloration and there was a skin tear. LPN 1 stated that the wound looked like it may have been an old skin tear that was reopened. LPN 1 stated that this was a new injury and it was bleeding at the time. LPN 1 stated that she sent the photo to the MD directly via a secured phone app. LPN 1 stated that there were other red marks on resident 1's chest right below his neck, and they appeared to be new. LPN 1 described the red marks on the chest as, like when a child was red in the face from crying. LPN 1 stated that the skin tear was the size of a fingernail and was sliced, it was freshly opened, and the skin was frail. LPN 1 stated that resident 1 didn't speak much English and kept pulling his arm away and grimacing. LPN 1 stated that resident 1 was telling her what happened in his language, but she was unable to understand. LPN 1 stated that the ADM called resident 1's daughter to translate. LPN 1 stated that in the photo the wound closest to her hand was an old scab and the one that was further away was the new injury. LPN 1 stated that she notified the MD and he ordered to transport the resident to the ER for evaluation. LPN 1 stated that she filled out the incident report, and she documented the skin assessment on the progress note in the incident report. LPN 1 stated that they called CNA 1 into the office, and she was escorted from the facility within minutes. LPN 1 stated that resident 1 was very tearful and crying. LPN 1 stated that resident 1 would yell out and cry when he was in pain, and that was how she knew when he needed pain medication. LPN 1 stated that this was an indication to her that he was hurting because he was crying and pulling away. LPN 1 stated that she was present when resident 1 returned from the ER, and they did not identify any other injuries in the ER. LPN 1 stated that communication could be difficult with resident 1. LPN 1 stated resident 1 was able to say yes/no, and when reminded to speak in English he could use some words. LPN 1 stated resident 1 could say pain, and gesture at the location. LPN 1 stated that resident 1 was on a tube feed at the time of the incident. LPN 1 stated that CNA 3 had told CNA 1 to turn off the tube feed while she was turning and repositioning resident 1 for incontinence care. LPN 1 stated that CNA 3 reported that she provided instructions to CNA 1 and she did not like it and said she could do it her way.