STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515140	A. Building B. Wing	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Health Care of Logan	135 Bills Branch Road Logan, WV 25601

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. (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 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, the facility failed to ensure residents were free from physical abuse when Resident#12 physically assaulted another resident , resulting in actual physical injury. This failure resulted in actual harm and had the potential to affect all residents residing in the Long Term Care facility. Residetn Identifier: #11 and #12 Facility Census: 111This failed practice was consider to be at past non-compliance, as the facility identified and corrected the failed practice prior to surveyors entering the building. Findings Include:Review completed on 10/21/25 of Resident #12 clinical record revealed a history of psychiatric illness with repeated verbal and physical aggression toward staff and peersThe care plan (initiated 12/26/24, updated 6/04/25) addressed Verbal/Physical Aggression with interventions to:Redirect using a calm, non-threatening tone.Encourage coping skills (deep breathing, quiet time).Monitor for triggers and increased agitation.Offer sensory tools and reassuranceResident-to-Resident Assault (6/14/25) resulting in actual harmProgress Notes:6/14/2025 14:53Note: Called to [NAME] Wing by staff, resident #11 noted to have altercation with resident #12 from 123-A. Resident from 123-A was attempting to move this residents w/c in the hallway to allow other residents to get by. This resident grabbed resident from 123-A by his shirt and attempted to pull him. Resident from 123-A struck this resident two times in the face with a closed fist. Residents separated resident noted to have superficial lacerations to left eye and large hematoma to left side of his forehead. Staff applied ice packs to areas where resident was refusing to keep ice pack in place. Resident at nurse station at this time. Call placed to POA and made aware of the situation. Dr. aware. 6/14/2025 15:09Note: Called to [NAME] Wing by staff, this resident #11 noted to have altercation with resident #12 from 101-A. This resident stated he was attempting to move resident from 101-A in the hallway when Resident #11t from 101-A grabbed Resident #12 by his shirt. This resident#12 then struck resident #11 from 101-A in the face two times with a close fist. Residents separated. Dr. aware. Message left for DHHR. 6/14/2025 17:11Note: This nurse called ER in concerns to this resident #11. This nurse received report that resident #11 currently has orbital fractures to the left eye, a small subdural hematoma to the left side of the face and resident is currently awaiting approval to be accepted to another hospital due to reported brain bleed. Physician notified, aware. Responsible party was notified. 6/16/2025 08:30Note: Called [NAME] County Sheriff's office at [PHONE NUMBER]. Left message to have one of the officers call facility to discuss recent events regarding the resident's abusive behavior. 6/16/2025 10:45Note: Called [NAME] County Sheriff's office again to speak with officer, Informed that an officer would return call 6/16/2025 10:48Social Services Note: Went to speak to resident about the incident that happen on 6/14/2025. Resident stated, I beat his ass. 6/16/2025 15:12Note: Called Sheriff's office again. Spoke with officer who stated that he would be down to facility to take statement. 6/16/2025Officer Came to Facility. Spoke with this nurse and residents POA who is also Employee. Officer was given details of incident. Stated that he would let us know what he would be able to do. 6/17/2025 10:00Received call from Officer stating he would be in facility to arrest resident. 6/17/2025 10:50Corporal and Deputy Sheriff arrived with active arrest warrant signed by Magistrate listing two counts of felony malicious assault. Resident handcuffed, read [NAME] rights, cooperative, and escorted from facility at 1103 without incident.Review of facility's internal timeline (12/01/24-6/17/25) showed:Resident #12;12/05/24 Resident struck staff member.12/06/24 Psychiatric visit with [NAME], FNP including medication review and Pavilion referral.12/10/24-12/26/24 admission to psychiatric hospitalization at Behavioral Health Pavilion. (medications adjusted and group counselling attended by Resident #12)12/26/25 All staff in-service held by [NAME], FNP addressing topics including abuse, resident redirection. 3/30/25 After referral to Behavioral Health Pavilion denied.4/15/25 After a resident-to-resident event involving room mate being punched in the chest, Resident #12 was placed in a room on the opposite side of the building; referral repeated and denied.4/18/25 Psychiatric follow-up addressing room mate altercation; medication regimen reviewed by [NAME], FNP.4/30/25 Resident#12 pushed another resident in a wheelchair; nurse educated Resident #12 to notify nursing staff when other residents needed assistance. Verbalized understanding.5/01/25 Psychiatric follow-up with FNP with another medication review.5/19/25a€ 6/11/25 All staff in-service held addressing Resident #12 resident-to-resident aggression; 1:1 initiated. 6/14/25 Resident #12resident-to-resident aggression towards KD; 1:1 initiated.6/16/25 @ 08:30AMLogan County Sheriff Office contacted; voicemail left regarding resident's abusive behavior.6/16/25 @ 10:45AM [NAME] County Sheriff Office contacted; stated that an officer would return a call 6/16/25 @ 10:48 AM

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on observation and staff interviews, the facility failed to ensure that residents were free from skin irritation and rashes associated with the use of a laundry detergent known to cause skin irritation. This deficient practice has the potential to affect all residents within the nursing home and was substantiated for 3 of 3 residents reviewed during the long-term care survey process. Findings include: On 10/20/25 record review of complaint filed with the State Agency (SA) reviled residents that the laundry detergent that the facility was using was causing outbreaks for half of residents from neck to feet. No rashes on hands and face. On 10/21/25 at 1:45 PM this surveyor observed blue detergent stored in the laundry area. Hooked up to the laundry machine was a clear detergent. During an interview competed on 10/21/25 at approximately 1:50 PM with Laundry Aide #93 , who stated the facility has been using a hypoallergenic detergent for approximately two years. The laundry aide # 93 explained that the blue detergent is used when the hypoallergenic detergent is out of stock or unavailable. Laundry aide #93 further reported that when the blue detergent was used, some residents would experience itchiness or develop rashes. Laundry aide #93 also stated the detergent change was implemented after residents complained of itchiness and the development of rashes. This confirming the facility still had access to the Blue Laundry detergent that causes irritations and rashes to residents residing in the long term care facility. On 10/21/25 around 2:00 PM The administrator was informed of Laundry aide#93's statement/interview and of this surveyors observations of the Blue laundry detergent. The Administrator stated he was unaware that the blue detergent was still being stored and used and stated we will get that out of there now. This confirming the facility had previously been aware of skin-related concerns among residents.