STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515175	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Logan Center	Po Box 540 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and staff interview, the facility failed to report alleged physical abuse to the proper state agencies within the required two (2) hour timeframe. This is true for one (1) of seven (7) residents reviewed under the care area of abuse. Resident identifier: #32. Facility Census: 63. Findings include: a) Resident #32 On 06/09/25 at 1:00 PM, a review of the facility policy entitled, Abuse Prohibition was completed. The review found in section 7.2 of the facility policy states, Report allegations involving abuse (physical, verbal, sexual, mental) not later than 2 hours after the allegation is made. On 06/09/25 at 11:21 AM, a facility-reported incident (FRI) dated 03/05/25 regarding an allegation of physical abuse on 03/04/25 was reviewed. The review found the alleged physical abuse was not reported to the proper state agencies within the required two (2) hour time frame. The alleged incident took place on 03/04/25 at 10:45 PM; and was not reported until 03/05/25 at 9:15 AM. The timeframe from the alleged event to the time of reporting was 10 and 1/2 hours. On 06/10/25 at 3:30 PM, an interview was held with the Administrator. The Administrator stated, both NAs are no longer employed here .for poor work performance and a hostile work environment. I did not substantiate the abuse due to the NA who reported the incident recanted her statement. The Administrator further stated, I am aware the allegation was not reported within the two (2) hour timeframe .I did education with the NA who did not report the alleged incident to the nurse in a timely fashion.

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to develop a care plan in the area of fall prevention for Resident #42. Resident identifier: #42 Facility census: 63. Findings include: a) Resident #42 Resident #42 had a fall on 04/17/25. Resident #42 was assessed with bruising to forehead, ankle and knee. X-rays were ordered for the ankle and knee and neuro checks were ordered. Resident was sent to the local ER on [DATE] and was diagnosed with cerebral infarction due to unspecified occlusion or stenosis of right middle cerebral artery. Resident #42's medical record revealed a fall risk evaluation was performed on 03/12/25 and a care plan review started on 03/7/25. Fall risks were identified as a focus area, goals were to have no falls with major injury and minor injury. However, the Interventions were Encourage resident to consume all fluids during meals. Observe for and report signs and symptoms of nausea/vomiting, and observe for changes in medical status, pain status, mental status and medication side effects. This finding was verified by Employee #45 on 06/09/25 at approximately 4:50 p.m. On 06/09/25 at approximately 4:38 p.m., a record review for Resident #42 revealed the resident's care plan dated 03/7/25 showed the resident was identified for falls risk as a focus area with goals were to have no falls with major injury and minor injury. The Interventions listed in the care plan were Encourage resident to consume all fluids during meals. Observe for and report signs and symptoms of nausea/vomiting, and observe for changes in medical status, pain status, mental status and medication side effects. On 06/09/25 at approximately 4;40 p.m., an interview with Employee # 45 verified this finding. This finding was also acknowledged by the Administrator on 06/11/25 at approximately 1:00 p.m.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record review and staff interview, the facility failed to be free from accidents/hazards by leaving Resident #21 in a broken bed. Resident identifier #21. Facility census 63. Findings include: a) On 06/09/25 at approximately 3:29 p.m., a record review for Resident #21 revealed a progress note dated 02/27/24 by Employee #21. The note reflected that the resident's bed had been dysfunctional for 3 days after witnessing Resident #21 fall on 02/27/24. On 06/09/25 at approximately 4:09 p.m., an interview with the facility Administrator verified that Resident # 21 bed was malfunctioning and employee #21 did not remove the malfunctioning bed out of service on 02/24/24. This finding was also acknowledged by the Administrator upon exit on 06/11/25 at approximately 1:00 p.m.

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to provide food in the correct consistency per physician orders and resident's individual needs for Resident # 168 resulting in a choking incident requiring emergency response and hospitalization. This created an immediate jeopardy situation. This failed practice had the potential to affect more than a limited number of residents. The facility had corrected this situation that began on 12/04/24 on 12/09/24. This issue is cited at past noncompliance. Resident identifiers: #168, #33, #51, #22, #25, #47, #39, #35, and #59. Facility Census: 63. Findings included: a) Resident #168 Review of a Facility Reported Incident (FRI) documentation revealed Resident #168 had a choking episode on 12/04/24. The resident was transferred to an acute care facility and admitted . The resident was hospitalized from [DATE] to 12/11/24. It was reported that the resident was served broccoli that was not chopped. According to the FRI, the resident indicated and gestured he was choking and staff immediately administered Heimlich technique and was able to clear his airway. A statement from a visitor stated, she assisted staff lower the patient to the floor and stated, Patient was choking on broccoli. I put my hands on his throat and felt something and pulled out a chunk of broccoli. The resident was ordered a Dysphagia Advanced texture diet by the physician. According to the facility's Diet and Nutrition Care Manual, Foods that are difficult to chew are chopped, ground, shredded, cooked, or altered to make them easier to chew and swallow. The corporate recipe for broccoli florets stated, Dys. Adv.: Prepare per recipe. Remove needed portions. Transfer to food processor, chop to pea-size pieces. Resident #168's tray card for 12/04/2024 stated Broccoli Florets, Chop. A written statement form [NAME] # 67 on 12/05/2024 stated, If we get suspended then everybody in dietary needs to be suspended bc we never was told to chop broccoli up. In the report the Dietary Manager said she had given him broccoli not chopped bc (because) its usually overcooked. On 06/09/2025 at 7:55 PM, when the surveyor asked who was ultimately responsible for ensuring correct diets are delivered, the Administrator stated, Staff doing the meal .cook and aide check each meal that goes out. Aide reads diet order as they plate it. The facility's Meal Distribution Plan stated, 4. The nursing staff will be responsible for verifying meal accuracy and timely delivery of meals to residents/patients. The facility's plan of correction included: An audit by the Director of Nursing (DON) conducted on 12/05/24 for all residents to ensure diet orders are correct and accurate. - completed. (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- DON/designees will conduct an observation round on 12/05/24 for all residents to ensure the correct diet is being served. - completed. - Re-education to all staff beginning on 12/04/24 to ensure diet orders are followed and the correct diet is being served with a post-test to validate understanding. - completed 12/09/24. - The Dietary Manager will monitor starting 12/05/24 to ensure diets are correctly served during meal service across all meals for 2 (two) weeks including weekends and holidays, the 5 (five) times a week for 4 (four) weeks, then 3 (three) times a week for 4 (four) weeks the randomly thereafter. Audit was completed 02/13/25, then continued randomly through last documented date during the survey (06/09/25). - Results of monitors will be reported by the DON/designee monthly to the Quality Improvement Committee. On 06/08/25 at 12:17 PM, during the dining observation, the food served to following resident's matched their tray cards: Residents # 33, # 51, #22, #2, #25, #47, #39, #35, and #59. On 06/10/25 at 11:30 AM, the kitchen tray line was observed for all halls. Good communication between all dietary staff members to ensure the correct meals were served was exhibited. The resident's diets were called out to the cook and two errors were caught before the tray was placed on the cart to be transported and served to the residents.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation, record review and staff interviews, the facility failed to ensure safe operating essential equipment for the facility's ice machine and Resident 21's bed. Resident identifier: #21. Facility census: 63. Findings: a) On 06/08/25 at approximately 3:48 p.m., an observation of the ice machine located in the dining area revealed the drainage line coming from the ice machine goes directly into the floor drain. On 06/08/25 at approximately 3:53 p.m., an interview with the facility's Maintenance Director and Regional Maintenance Director verified this finding. This finding was also acknowledged with the facility Administrator upon exit on 06/11/25 at approximately 1:00 p.m. b) Resident #21 On 06/09/25 at approximately 3:29 p.m., a record review of Resident #21 revealed a progress note dated 02/27/24 by Employee #21. The note revealed that the resident's bed had been dysfunctional for 3 days after witnessing Resident #21 fall on 02/27/24. On 06/09/25 at approximately 4:09 p.m., an interview with the facility Administrator verified that Resident #21's bed was malfunctioning and Employee #21 did not remove the malfunctioning bed out of service on 02/24/24. This finding was also acknowledged by the Administrator upon exit on 06/11/25 at approximately 1:00 p.m.