STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515193	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arthur B Hodges Center, The	300 Baker Lane Charleston, WV 25302

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on electronic medical record review and staff interview, the facility failed to ensure the accuracy of a Minimum Data Set (MDS) for treatments for a resident with a pressure ulcer. This was true for one (1) of one (1) resident reviewed for pressure ulcers. Resident identifier: #118. Facility census: 17. Findings included: a) Resident #118 A review of the Significant Change MDS with an Assessment Reference Date (ARD) of 03/09/25 found the areas of Section C, D, and E were not marked. Section C was regarding turning and repositioning Section D regarded nutrition and Section E regarded Pressure Ulcer Care Resident #118 was receiving all these treatments. On 06/04/25 at 1:20 PM in an interview with the Director of Nursing (DON) and the Nursing Home Administrator (NHA) confirmed the Significant Change MDS did not include treatments the resident was receiving regarding a pressure ulcer.

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and staff interview, the facility failed to revise Resident #8 as it related to contractures. This was true for one (1) of nine (9) care plans reviewed during the survey process. Resident identifier: 8. Facility census: 17. Findings include: a) Resident #8 During a review of Resident #8's electronic health record on 6/02/25, it was noted the resident had a contracture of her right and left lower legs. A subsequent review of the resident's care plan revealed there was no mention of the contractures. Further review of Resident #8's records revealed she was diagnosed with stiffness in both the right and left knees in January of 2024, which was included in the care plan. The resident was diagnosed with contractures in both lower legs in April of 2025. During an interview with the Director of Nursing (DON) on 6/3/2025 at approximately 3:45 PM, she confirmed she did not see the contractures mentioned in the care plan. At approximately 4:00 PM on 06/3/25, during an interview with the MDS Nurse, it was confirmed the resident's care plan did not include the contractures, only the knee stiffness.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on record review and staff interview, the facility failed to follow physician orders as it related to sliding scale insulin administration, by failing to administer the insulin as directed. This was true for one (1) of five (5) residents reviewed for unnecessary medications during the survey process. Resident identifier: #2. Facility census: 17. Findings include: a) Resident #2 At approximately 9:30 AM on 06/03/25 during a review of Resident #2's Medication Administration Record (MAR) it was determined the resident had the following order for insulin administration on a sliding scale: Novolog flexpen 100 unit/ml sub-q. three times a day. accu check before meals with sliding scale coverage: 141-170- 1 unit. 171-200- 2 units, 201-230- 3 units, 231-260-4 units, 261-290- 5 units. 291-320- 6 units, 321-350- 7 units, 351-380- 8 units. 381-400- 9 units. Further review indicated, according to an entry at approximately 5:00 AM on 6/3/2025, the resident had a blood sugar of 148 which calls for the resident to receive one (1) unit of insulin, according to the physician ' s orders. The MAR reads the resident was administered zero (0) units at this time, as it was listed under the resident blood sugar reading. At approximately 2:05 PM on 06/03/25, an interview was conducted with the Director of Nursing (DON). During the interview, the DON confirmed the MAR indicated the resident had a blood sugar of 148 and was given no insulin.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interview, the facility failed to store, prepare, and serve food in a sanitary manner by leaving bags of frozen food open in the freezer. This was a random opportunity for discovery. This had the potential to affect more than a limited number of residents residing in the facility. Facility census: 17. Findings include: a) During the initial tour of the kitchen on 06/02/25 at approximately 11:45 AM, one (1) bag of burgers and one (1) bag of carrots open, in the freezer, exposed to the elements. This was confirmed by the Dietary Manager (DM), at the same time, who was present during the tour.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and staff interview, the facility failed to accurately document the percentage of meal intake for Resident #118. This was true for one (1) of one (1) residents reviewed for weight loss during the survey process. Resident identifier: 118. Facility census: 17. Findings include: A) Resident #118 During a review of Resident #118 ' s electronic medical record on 6/4/2025, it was determined the facility did not document the percentage of meals consumed by the resident on the following days: 11/14/2024- Lunch 11/28/2024- Lunch 12/2/2024- Lunch 12/5/2024- Lunch 12/31/2024- Breakfast 1/2/2025- Breakfast and Lunch 1/28/2025- Lunch 1/29/2025- Lunch 3/12/2025- Lunch 3/14/2025- Lunch 4/10/2025- Lunch 4/26/2025- Lunch 5/13/2025- Lunch 5/19/2025- Lunch 5/25/2025- Lunch At approximately 2:05 PM on 6/4/2025, an interview was conducted with the Director of Nursing (DON). During the interview, the DON confirmed the missing meal percentages.