STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515167	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shenandoah Center	50 Mulberry Tree Street Charles Town, WV 25414

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interviews, the facility failed to ensure resident's environment remained as free of accident hazards as is possible in regard to resident's rooms and vanity drawers, to be free of razors, scissors, and inedible care items in the 300 hall, mounted wall heater and broken inwall receded night light in resident bathroom, also resident's bedside table with a straw in her lotion bottle. This failed practice was a random opportunity for discovery. Resident identifier: #'s 3, 44, 50, 56 , and 88. Facility Census: 76.Findings Included: a) room [ROOM NUMBER] -During facility walk through and resident interviews on 03/05/26 at 10:56AM, 4 cans of shaving cream and 2 opened packages of razors, among other bathing products such as body lotions, shampoo, and mouthwash were found in the top 2 (two) drawers of the resident's shared sink/vanity area in room [ROOM NUMBER]. These drawers were easily accessible to any resident that may wander into the room. During an interview with Resident #3 he stated the top two drawers were not his. They belonged to his room mate. Resident #3 stated he had made complaints that resident #50 gets into his bedside drawers and all other drawers in the room. b) Rooms #301 and #303 Shared bathroom On 03/05/26 at 10:16AM during entrance interviews and facility walkthrough, it was observed in the shared bathroom between room [ROOM NUMBER] and #303, the top of the metal baseboard heater was broken protruding and jagged edges. Further observation found a broken encased wall night light with the glass cover out of place exposing the glass bulb and electrical wiring. In an interview with the Environmental Account Manager #89 on 03/05/26 at 10:35AM, she acknowledged the hazards in the shared bathroom for room [ROOM NUMBER] and #303, and stated she would report it to the maintenance department for immediate repair. In an interview with the Facility Administrator on 03/06/26 at 9:54AM, she stated she was made aware of the hazards in the shared bathroom of room [ROOM NUMBER] and #303 and stated maintenance were actively repairing it.

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 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, interview and policy review the facility failed to properly store food in accordance with professional standards. issues with food storage were found in the facility kitchen freezer This had the potential to affect all residents in the facility. Facility census: 76On 03/09/26 at 11:10 AM, during the 2nd kitchen visit, with the Corporate Dietary Manager (CDM) revealed the CDM acknowledged the following in the freezer : -1(one) opened box of frozen ground beef with inner plastic unsealed and left open to air -1(one) opened box of fish filet's with inner plastic unsealed and left open to air Interview with Kitchen Manager on 3/9/26 at 11:10 AM, He acknowledged the frozen ground beef and frozen fish filets were left open to air and stated the staff were supposed to tie the plastic to reseal once they have been opened. -On 03/10/25 at 2:35 PM a review facility policy labeled HCSG (Health Care Services Group) Policy 019, Food Storage: Cold Foods. Procedures, number 5 stated All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on observation, staff interview and resident interviews it was determined that the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Several issues were identified related to staff response times to call lights. Facility census: 76.Findings Included:a) Resident #11On 03/05/26 at 2:50 PM after completing a representative Interview with Resident #11's family member outside his room, it was observed his call light was on. Upon walking into his room, he stated he was trying to call for staff. At 3:17PM two Nurse Aide (NA) #68 and #72 came in and asked if they could help him. Resident #11 asked for a glass of water and the bed pan. One NA stated she would get the water for him and the other stated she would get him someone to help him with his bed pan and the NA left the room. At 3:25 PM Nurse Aide #45 came in to assist him with the bed pan. On 03/05/26 at 3:35 PM during an interview with NA #45 the NA acknowledged Resident #11's wait time of 30 minutes for the help and care he needed and stated, Thank you for letting me know.On 03/05/26 at 4:25 PM during an interview with the Director of Nursing (DON), she stated she was aware of the amount of time Resident #11 had to wait for his call light to be answered and stated it was too long and not acceptable.03/05/26 at 2:50 PM during a family interview Resident #11's sister stated her brother hates to ask staff for help because he had to wait too long for help and they are always saying they are so busy that it takes long periods of time for them to get to him. She reported on 03/05/26 he needed to be changed when she got there. She said his skin was getting red from being in feces too long. She stated she was going to speak the DON.b) Resident #4On 03/04/26 at 2:00 PM, Resident #4 who had capacity stated, At times I have waited 45 minutes for someone to answer my call light. When asked if this happens on any specific shifts or days, he stated mostly dayshift but has been other times as well.c) Resident #61On 03/04/26 at approximately 2:20PM, Resident #61 reported that sometimes call lights take longer than a half hour to get answered as the staff tells her they are very busy. d) Resident #3On 03/05/26 at 11:15AM Resident #3 stated he had waited 30 minutes for his call light to be answered.Resident Council meeting held on 04/05/26 at 10:30 AM residents with capacity in attendance expressed concerns regarding long wait times for call lights to be answered.e) Resident #9Resident Council [NAME] President, Resident identifier #9, stated he felt the nursed aides are nice and are trying very hard but he has had to wait up to 45 minutes for his call light to be answered.f) Resident #71Resident #71 stated she has had to wait 30 minutes for her call light to be answered and sometimes they forget to come back if they turn it off and say they will return. g) Resident #29Resident #29 stated he has had trouble with staff not coming to answer his call light for up to 45 minutes and sometimes it takes longer depending on who is working.On 03/05/26 at 3:35PM during an interview with Nurse Aide employee identifier # 45 acknowledged resident # 11's long wait time of 30 minutes for the help and care he needed and stated thank you for letting me know.On 03/05/26 at 4:25 PM in an interview with the Director of Nursing, she stated she was aware of the amount of time Resident #11 had to wait for his call light to be answered and stated it was too long and unacceptable.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. The facility failed to ensure a dignified existence for residents. Resident #16 Based on observation and staff interviews the facility failed to ensure resident #16 had a right to a dignified existence Inside the facility.This failed practice was a random opportunity for discovery. Resident #16. Facility Census 76.Findings Included:On 03/04/2026 at 11:46 AM during a facility walk through on the 100 hall it was observed that Resident#16's private areas and brief was exposed with the room door wide open. Three staff members were observed present in the hall with visuals into the room and did not offer privacy for the resident prior to surveyor staff bringing it to Employee #36's attention. Employee #36 then stepped into the room and pulled the curtain for privacy. In an interview with the Director of Nursing on 03/04/26 at 12:15 PM, she acknowledged the door was open while Resident #16's son was changing her but staff members in the hall did not provide privacy for resident until surveyor staff brought it to their attention.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on record review and staff interview, the facility failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNF-ABN) form to one (1) of three (3) residents reviewed for the facility's beneficiary protection notification practice during an annual survey. This failure placed the resident at risk of not being informed of his rights prior to the end of Medicare Part A covered services. Resident identifier: #31. Facility census: 76.Findings included: a) Resident #31On 03/10/26 at 11:02 AM, a beneficiary notification record review was completed.Resident #31 remained in the facility after his last covered Medicare Part A day on 11/11/25. There was no evidence that the SNF-ABN was ever reviewed with the resident. During an interview on 03/10/26 at 12:24 PM, the Business Office Manager reported that a SNF-ABN had not been issued.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to provide a written Bed Hold Notice for one (1) of three residents. Resident #45 was discharged to an acute care setting. Resident Identifier: #45. Facility Census: 76.Findings included: a) Resident #45An electronic medical record review was completed on 03/10/2026 at 9:56 PM. Resident #45 was transferred to the hospital on [DATE]. There was no evidence in resident's medical record to reflect that a bed hold notice had been provided to the resident or the resident's representative. During an interview, on 03/11/26 at 8:30 AM, the Administrator acknowledged the facility could not provide evidence that a written bed hold notice had been given.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on resident interview, record review, and staff interview, the facility failed to ensure a resident received trauma-informed care which accounted for the resident's experiences and preferences in order to mitigate triggers that may cause re-traumatization. Resident identifier: #62. Facility census: 76. Findings included:a) Resident #62 During an interview, on 03/05/26 at 9:18 AM, Resident #62 revealed she had a Post-Traumatic Stress Disorder diagnosis stemming from a marriage involving severe domestic violence. The resident reported that loud voices directed towards her, closed doors, and any rough handling would be potential triggers for her experiencing re-traumatization. A medical record review, completed on 03/10/2026 at 10:08 PM, revealed a Social Services Assessment which reflected the PTSD diagnosis and the potential trigger of yelling. However, review of Resident #62's care plan did not find the PTSD diagnosis and potential triggers for experiencing re-traumatization addressed in any fashion. On 03/11/2026 at 9:50 AM, the Social Worker confirmed resident's care plan did not address the resident's PTSD diagnosis. The Social Worker acknowledged lack of proper care planning could potentially lead to re-traumatization of the resident, resulting in unnecessary mental anguish.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections . This failed practice was a random opportunity of discovery. Resident identifiers: #94, #9, #55, #12. Facility census: 76.- 03/04/26 at 12:04 PM: It was observed that Employee #7 handled Resident #94's hamburger buns without gloves.- 03/04/26 at 12:06 PM: During an interview, Employee #7 acknowledged the incident and stated she returned the plate to the kitchen for a replacement. - 03/04/26 at 9:55 AM: In room [ROOM NUMBER], the wheelchairs for Resident #9 and #55 had rips and tears on both armrests, exposing the inner padding.- 03/04/26 at 10:00 AM: Resident #12's wheelchair was observed to have holes and tears in the right armrest with exposed inner padding.- 03/04/26 at 2:50 PM: During an interview, the Facility DON and Administrator acknowledged the condition of the wheelchairs and agreed that the damaged arm pads cannot be properly sanitized to prevent infection. They stated that a facility-wide audit will be completed to address wheelchair repairs and replacements.