

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515179	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2026
NAME OF PROVIDER OR SUPPLIER Canterbury Center		STREET ADDRESS, CITY, STATE, ZIP CODE 80 Maddex Drive Shepherdstown, WV 25443	
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident interview, and staff interview, the facility failed to ensure the rooms are being kept in a clean/comfortable/homelike environment for four (4) of nine (9) rooms throughout the Long-Term Care Survey Process. Room identifiers: #301, #305, #306. Resident identifier: #4. Facility census: 59. Findings included: a) room [ROOM NUMBER] On 07/12/26 at 11:45 AM the following observation was made of room [ROOM NUMBER]'s bathroom: A bed pan was placed on the floor. Also, in the room trash debris was on the floor between and under the beds. Nursing Assistant #24, verified the bed pan should have been off floor and the room cleaned, stating On the weekends house keeping is scheduled one person usually. b) room [ROOM NUMBER] In room [ROOM NUMBER] trash can had trash overflowing under the sink and in bathroom. Nursing Assistant #24 verified the room and bathroom needed cleaned. c) room [ROOM NUMBER] On 07/12/26 at around 12:00 PM, in room [ROOM NUMBER] the state surveyor (SS) observed the trash can had trash overflowing with trash debris and a soiled brief in it. Nursing assistant (NA) #24 verified trash was over flowing and the brief should not have been in there. She stated, I have been running around like crazy today - staffing is a bit low. d) Resident #4 On 07/12/2026 2:00 PM during an interview with the SS Resident #4 stated her bedside table was dirty and never got cleaned. SS observed that the bedside table was soiled and needed cleaning. ON 07/13/26 at 11:12 AM the SS went to Resident #4 room to check on her. She was not in her room. The SS saw a wet floor sign. The floor was dry. The room looked to have been cleaned, but the (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bedside table was still soiled and needed cleaning. The SS asked Registered Nurse #99 if the bedside table looked soiled to her. She stated, It is soiled and we will get it cleaned.		

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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 observations, resident interviews, record review and staff interviews. The facility failed to ensure call lights were answered in a timely fashion to ensure residents needs are met, additionally the facility failed to ensure resident's received treatment and care in accordance with professional standards of practice. Specifically, physician's orders were not followed. For five (5) of (22) residents reviewed during the long term care survey process. Facility census 59. Resident indicators. #8, #39, #41 and #79, #4 Findings include; a) Review of grievance reports: -02/10/26 grievance of long call light times -02/17/26 grievance of long call light times evening and night shifts -03/03/26 grievance of long call light times during the day -03/10/26 grievance of call light are slow to being answered -03/17/26 grievance of long call light times on night and early morning shifts -04/24/26 grievance of long call light time -04/24/26 grievance of long call light time -04/24/26 grievance of long call light time -04/24/26 grievance of long call light time -04/24/26 grievance of long call light time -04/24/26 grievance of long call light time -04/24/26 grievance of long call light time -04/24/26 grievance of long call light time -04/24/26 grievance of long call light time -04/24/26 grievance of long call light time -04/24/2026 grievance of long call light time -04/24/2026 grievance of long call light time (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-04/24/2026 grievance of long call light time -04/24/26 grievance of long call light time -04/24/26 grievance of slow call light response between 8pm and 12 am and call lights being turned off without assistance until later. -5/12/26 grievance of long call light times -05/26/26 grievances of call light response times are varied across shifts. -06/02/26 grievance of long call light times around meal pass. -06/30/26 grievance of slow call light times b) Review of resident council meeting minutes: -02/10/26 concern of long call light times reported by multiple residents over the past week. -02/17/26 Residents reported long call light times in the evening and night shifts. -03/03/26 multiple residents reported long call light times in the morning and night. -03/10/26 concern that call light times are still slow on some days -03/17/26 residents report long call light times mainly on night and early morning shifts -04/28/26 residents report slow call light response times from 8pm-12am and call lights are being turned off without assistance until later. -05/12/26 residents report call lights go unanswered on the night shift -06/30/26 residents report call light times have been slower than expected this past week on varied shifts and days. On 07/12/26 at around 12:10PM Resident #8 asked for her call light, reporting need someone and I cant find my call light. The State Surveyor (SS) observed the call light was on the floor between the side rail and mattress. The SS turned on call light for resident at this time. At around 12:35 PM, the Activity Director (AD) walked into the room to answer the call light. The SS questioned how long it generally took to answer call lights specifically during meals and on weekends. The AD reported, Usually pretty quick, but her aide was helping another hall. Resident #8 requested call light to be in reach. The AD verified the call light was not in reach and repositioned it. Resident #8 reported to activity director, My call light had been on since 12:10. It is now 12:35 PM. That is a long time. The AD reassured Resident #8 that they would do better at answering. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/12/26 at around 12:55 PM the SS observed that the call light for Resident #8 was on. SS was observing for meal service. At 1:15 PM the call light remained on and no staff was observed on the unit. The SS observed that the meal delivery cart was brought to the unit at 12:50 PM. At 12:20 PM Nurse Aide (NA) #24 began meal service and the all light remained on. The SS questioned NA #24 if staff answered call lights during meals, she replied We usually answer, I was in there a couple minutes ago. SS reported to NA #24 that their observation was being done since 12:50 PM with no staff being on the unit until 1:20 PM. NA #24 reported, Oh, I was down another hall passing trays, I am sorry. On 07/12/26 at around 2:10 PM, Resident #39 reported, When I put on my call light it takes a long time, sometimes I wet myself. Like now. They tell me they are short staffed. Most days I try to wait and not bother them. On 07/12/26 at around 1:30 PM during follow up interview, Resident #79 reports, I have only been here since Friday but they need more staff, it takes along time to get a call light answered. They are even telling me they are short staffed On 07/12/26 at around 3:45 PM, Resident #41, was interviewed with her daughter. Resident #41 she reported, It doesn't seem like they have enough staff, seems like there is always one aide on a hall , the nurses try to help but they are busy too d) Resident #4 During an interview with the State Surveyor (SS) on 07/12/26 at 2:00 PM Resident #4 stated that she fell two months ago. She said she fell out of a shower chair. Resident #4 said the facility waited three days to get an x-ray. 07/13/26 1:00 PM Pn 07/13/26 the SS reviewed the medical record of Resident #4 and determined that Resident #4 had a fall on 03/27/26 at 7:45 PM. Further review of the medical record revealed that on 03/29/26 the Physician ordered an X-ray of the right knee, right foot and sacrum due to complaint of pain. The X-ray was obtained for her right knee and foot but not her sacrum. 07/13/26 1:30 PM On 07/13/26 at 1:30 PM the state surveyor asked the Director of Nursing (DON) why Resident #4 did not receive an X-ray for her sacrum as ordered by the physician on 03/29/26. She stated, I am not sure, I will ask the staff and the Nurse Practitioner (NP) and get back to you. On 07/13/26 at 2:32 PM the DON stated to the SS, I could not find out why Resident #4 did not receive the X-ray for her sacrum. I have notified the Physician about the omitted X-ray for Resident #4 back on 03/29/26. I am going to complete a significant change and a pain assessment on Resident #4.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review and staff interview the facility failed to ensure pharmacist recommendations were acknowledged by the physician. This was true for one (4) of Five (5) residents reviewed for the care area of unnecessary medication. Facility Census: 59. Resident identifiers: #43, #4, #54, and #56. Findings Included: a) Resident #43 The Consultant Pharmacist (CP) completed a Medication Regimen Review (MRR) on 10/21/25. The Consultant Pharmacist (CP) recommended (as Written): The resident was prescribed diclofenac gel 1% to knees twice daily for pain relief. The current order did not specify the amount. Recommended dosing for diclofenac gel.: Upper Extremity: Apply 2g gel each affected area up to 4 times daily (maximum dose per joint is 16g/day) Lower extremity: Apply 4g to each affected are up to 4 times daily(maximum daily dose per joint of 8g/day) Maximum Daily dose (ll joints combined): 32g/day Please update the resident's diclofenac gel 1% order to specify the amount of grams to be applied. The physician did not respond to or acknowledge this recommendation. The CP completed a Medication Regimen Review (MRR) on 11/12/25: The CP recommended (Typed as written): The resident is prescribed diclofenac gel 1% to knees twice a daily for relief of pain. The current order does not specify amount. Recommended dosing for diclofenac gel: Upper Extremity: Apply 2g gel each affected area up to 4 times daily (maximum dose per joint is 16g/day). Lower extremity: Apply 4g to each affected are up to 4 times daily(maximum daily dose per joint of 8g/day) Maximum Daily dose (all joints combined): 32g/day Please update Resident's diclofenac gel 1% order to specify amount of grams to be applied. The physician did not respond to or acknowledge this recommendation. During an interview with the Director of Nursing (DON) on 07/14/26 at 9:40 AM, she was asked why the facility had not acted on these pharmacy recommendations. She stated, I do not know, I came here in December 2025. c) Resident #54 A medical record review for Resident #54 revealed monthly drug regimen reviews response without physicians review, actions or rationale. On 07/22/25, the Consultant Pharmacist (CP) recommended the following: Resident is receiving probiotic Florastor twice daily. No noted GI complaints. Could this be considered to stop at this time? (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No Physician response was noted. During an interview on 07/15/26 at 11:02 AM the Administrator verified that the physician did not review the recommendation or note the action or rationale. d) Resident #56 A medical record review for Resident #56 revealed monthly drug regimen reviews from the CP. 11/19/25 Recommendation from the CP: Federal guidelines for long term care facilities require an evaluation of antipsychotic usage upon admission. This resident was recently admitted with an order for Olanzapine ODT 10 MG two times a day to treat psychosis management. 11/19/25 Recommendation from the CP: Resident is currently receiving Escitalopram and Trazodone for depression. The combined use of more than one antidepressant medication has not been demonstrated to be more effective than a single agent and has potential to increase side effects. During an interview, on 07/15/26 at 11:02 AM, the Administrator verified that the physician did not review the recommendation or note the action or rationale. b) Resident #4 The Consultant Pharmacist (CP) completed a Medication Regimen Review (MRR) on 09/24/25 for Resident #4. The Consultant Pharmacist (CP) recommended to increase Glargine insulin dose or routine Lispro insulin doses to lessen the need for corrective Lispro insulin. This recommendation was not acknowledged by the facility. The CP completed a Medication Regimen Review (MRR) on 10/21/25 for Resident #4. The CP recommended to increase Glargine insulin dose or routine Lispro insulin doses to lessen the need for corrective Lispro insulin. The facility had no evidence reflecting that this recommendation was acknowledged. The CP completed a Medication Regimen Review (MRR) on 11/11/25 for Resident #4. CP recommended increasing the Glargine insulin dose or routine Lispro insulin doses to lessen the need for corrective Lispro insulin. This recommendation was not acknowledged by the facility. State Surveyor (SS) asked DON during an interview on 07/14/26 at 9:40 AM why the facility had not acted on these pharmacy recommendations She stated, I do not know, I came here in December 2025.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, resident interview, and staff interview, the facility failed to ensure palatable food. The noon meal on 07/12/26 was served late and cold causing food to be too tough to cut or chew. This was a random opportunity for discovery that had the potential to affect more than a limited number of residents. Resident Identifiers: #47, #9, #19, #44, #37, #28, #2, #36, #25, #11, #4, #43, #78, #14, #57, #60. Facility Census: 59 Findings Included: a) During the first kitchen visit on 07/12/26 at 11:55 AM, kitchen staff reported that due to being short-staffed, no residents would be served in the dining room at the usual time of 12:00PM. A short time later at 12:10 PM, the kitchen was notified that because the state is here the dining room had to be open. The Dietary Manager had already placed usual dining room resident's meal tickets back in the stack for room delivery. Dining room observation on 12:25 PM revealed Resident #47, #9, #19, #44, #37, #28, #2, #36, #25, and #11 were in the dining room at 12:25 PM waiting to be served. At 12:40 pm, The frist trays served in the dining room to Resident #9, #19, and #47. This was 40 minutes late. Resident #47 refused her tray stating she could not cut/chew the meat. At 12:50 PM, It was observed Resident #44 received her tray which was 50 minutes late. At 1:20 PM Resident #11 became very upset and asked several times What is going on here. Am I going to eat or not? By 1:25 PM, she decided to go back to her room but was given the tray that was left sitting on the counter. When staff was asked where the tray came from she stated it was An extra one. The surveyor asked if the tray might be too cold to serve; she stated, Oh, maybe. and went back to check with Resident #11 who stated the tray was too cold to eat. At 1:30 PM Resident #11's tray arrived after it had been sent to her room and then back to the dining room and was given to her to replace the rejected extra tray. Again the surveyor asked the staff if that tray was also too cold. She checked again, confirmed it was cold, and took it to be heated. It was then given to resident # 11 at 1:35PM. Also at 1:30PM Resident #2, #36, #25, #37, and #28's trays arrived after they had been sent to their rooms and then back to the dining room. Resident #37 stated she could not eat her tray as it was cold and stated the meat was too tough,. Resident #37 said, I don't want to break my teeth on that meat. In an interview with the Dietary Manager (DM) on 07/12/26 at 12:10 PM, the DM reported the dining room was originally supposed to be closed for the noon meal due to the facility being short staffed. The change of opening the dining room caused the meals to be served later than scheduled time of 12:00 PM In an interview with the facility Administrator (FA) and the Corporate RN (CRN) on 07/13/26 at 9:00AM, the FA and CRN stated they would have liked to have known about it sooner but (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	acknowledged the noontime meals were served late with cold and tough food in the dining room the previous day. -On 07/12/2026 at around 1:50 PM Resident #78 called this surveyor to room, and reported, I am not sure what this meal is supposed to be but the meat is tough, the mashed potatoes are runny, The surveyor observed the meat was tough to cut and mashed potatoes running on the plate. -On 07/12/2026 at around 1:30 PM Resident # 57, reported, The food is sometimes alright, a lot it is cold, they take along time to pass trays. Today the meat was really tough and gravy was not good. -On 07/12/2026 at around 2:00 PM Resident #14, reported,. I don't like any of the food, the meat is usually too tough to eat. And cold by the time they pass. -On 07/12/2026 at around 2:00 PM, Resident #37 reported, The food is usually not good it is cold half the time because the aides take along time to pass trays. -On 07/12/2026 at around 3:30 PM. Resident #60 reported, The food is usually not too good. Today for instance the meat was really tough, couldn't hardly chew it, and the mashed potatoes were runny.		

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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. This was true for the facility kitchen and nourishment pantry. This had the potential to affect all residents in the facility. Facility census: 59 Findings included: a) Initial Kitchen Visit: On 07/12/26 at 11:44 AM, during an Initial Brief Tour of the Kitchen, with the Dietary Manager (DM) the DM acknowledged the following:- in the walk in cooler, an opened box of bacon not sealed and left open to air- in the refrigerator, a ketchup container with a hole the corner of the lid exposing the condiment to open air, - in both of the 2 (two) utensil drawers, the scoops were not stored all in the same direction. b) Nourishment room walkthrough: On 07/13/26 at 11:15AM during a walk through in the nourishment room with the Dietary Manager (DM) the DM acknowledged the following: the refrigerator thermometer found the temperature inside was 48 degrees. The Dietary Manager stated she would request maintenance to check it. c) Facility Food Storage Policy: On 07/14/26 at 3:00 PM the surveyor reviewed the facility policy labeled HCSG Policy 019, Food Storage: Cold Foods. Procedure 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. d) Staff Interview: On 07/15/26 at 9:00 AM, the surveyor interviewed the Facility Administrator (FA), Director of Nursing (DON) and the Corporate RN (CRN). The FA, DON, and CRN acknowledged the exposed box of bacon in the walk-in cooler, the open condiment in the refrigerator, the incorrectly stored utensils in the kitchen, and the 48-degree refrigerator temperature in the nourishment room, and they made a list of the findings.		

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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. Based on observation, and staff interview the facility failed to treat each resident with respect and dignity during the lunch dining experience. This was a random opportunity for discovery. Resident Identifier: #54. Facility census: 59 Findings included: a) Resident #54 An observation of meal service on 07/09/26 at 12:40 PM, found Nurse Aide (NA) #66 standing over Resident #54 assisting with his lunch meal. During an interview on 01/12/26 at 12:19 PM the Director of Nursing (DON) verified that staff should assist residents with meals while sitting beside them, not standing over the resident.		

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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. Based on record review, and staff interview, the facility failed to ensure Resident #38 had a person-centered comprehensive care plan developed and implemented to meet his / her other preferences and goals, and address the resident's medical, physical, mental, and psychosocial needs. This practice affected one (1) of (22) resident's care plans reviewed during the Long-Term Care Survey Process (LTCSP). The failure to ensure the comprehensive care plan was developed for the resident's highest practicable well-being placed the residents at risk of not receiving services that would meet their desires or wants and a decreased quality of life. Resident Identifiers: #38. Facility census: 59. Findings included: a) Resident #38 Review of the medical records for Resident #38 revealed a preference for no male caregivers in the special instructions. Subsequent review of the comprehensive care plan and physician orders indicated that the instruction for no male care givers was only documented within the special instructions section rather than integrated into the primary care goals or active physicians orders. During an interview on at 12:47 PM, the Social Service Director (SSD) verified she has never interviewed Resident #38 about her preferences of care givers. On 07/15/26 at 1:15 PM, an interview with the Director of Nursing confirmed that the directive for No male care givers was not properly reflected in the resident's care plan or physician orders to ensure all staff were alerted to the request.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, record review and staff interview, the facility failed to ensure one (1) of one (1) resident received the assistance needed with activities of daily living. Resident identifier: #4. Facility census: 59. a) Resident #4 During an interview with the State Surveyor (SS) on 07/12/26 at 2:00 PM Resident #4 stated she had not had a shower in three (3) weeks. She stated she was supposed to get a shower every Monday and Friday. She became teary-eyed and stated, My hair is greasy and I cannot do it by myself. Resident #4 had capacity to make medical decisions. On 07/13/26 at 12:08 PM the SS spoke with the Director of Nursing (DON), the Clinical Lead Nurse (CLN) and the Administrator (ADM) about Resident #4 stating that she was not getting showers as she would like to. On 07/13/26 at 12:16 PM the CLN gave the SS a copy of Resident #4's bathing documentation from her medical record. It did show that Resident #4 was receiving bed baths instead of showers. On 07/13/26 at 1:30 PM the SS asked the DON, ADM and CLN why Resident #4 was receiving bed baths instead of showers. The CLN stated, I am not sure, but I will check for refusals. On 07/14/26 at 10:18 AM the SS asked the DON, ADM and CLN if they figured out why Resident #4 was not getting showers. The CLN stated. I cannot tell you that she refused these showers. I do not have proof. A review of Resident #4's care plan revealed the following: Focus: Resident requires assistance for ADL (Activities of Daily Living) care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting, related to ESRD-Dialysis, Asthma and Diabetes. Goal: Residents ADL care needs will be anticipated and met throughout the next review period. Interventions: Provide resident with substantial/maximal assistance for bathing. Resident #4 was admitted on [DATE] and her base care plan was created on 12/16/24. The base care plan had not been updated regarding her bathing preference. She had capacity and during her interview on 07/12/26. During that interview she stated she preferred showers. On 07/14/26 at 12:49 PM the State Surveyor (SS) spoke with the DON, CLN and ADM about Residents #4 care plan not showing her bathing preference as wanting showers. They stated, We will get her care plan updated to reflect this.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515179	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2026
NAME OF PROVIDER OR SUPPLIER Canterbury Center		STREET ADDRESS, CITY, STATE, ZIP CODE 80 Maddex Drive Shepherdstown, WV 25443	
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 - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, and staff interviews, the facility failed to ensure the resident environment under its control was as free from accident hazards as possible. An observation of Resident #28's room found a spray bottle of disinfectant cleaner on her bedside dresser. Additionally, observations revealed a housekeeping cart and a treatment cart were left unlocked and unattended, and doors to central supply and the service hall were also found unlocked. These failed practices presented random opportunities for discovery and could affect more than a limited number of residents. Facility census: 59. Findings included: a) Resident #28 On 07/13/26 at 2:10 PM, a white/green spray bottle of disinfectant/cleaner was observed sitting on Resident #28's bedside dresser which was witnessed and confirmed by Housekeeping (HK) #82 and #101. HK #82 removed it and took it to the Director of Nursing (DON). During an an interview with the DON, on 07/13/26 at 2:20 PM, she acknowledged the spray bottle of cleaner was found in Resident #28's room and stated she was going to check with the family to see if they brought it into the facility. On 07/12/26 at around 11:45 AM, the state surveyor (SS) observed an HK cart near the Dining Room (DR) left unattended and unlocked. SS observed the housekeeping (HK) cart for five (5) minutes while residents entered and exited the dining room. Laundry Aide (LA) #107 verified this needed to be locked since residents are coming and going in the dining room. On 07/12/26 at around 11:45 AM the State Surveyor (SS) observed the door to a room at the end of the service hall unlocked with a case of water blocking the entrance. LA #107 verified it needed locked. At around 1:45 PM the door at the end of the service hall remained unlocked with the case of water blocking it from opening fully. The Dietary Manager (DM) verified this door should be locked at all times. On 07/12/26 at around 12:00 PM the Treatment Cart (TC) near the resident lounge was unlocked and unattended. At 12:10 PM Registered Nurse (RN) #69, came to ask if this surveyor needed anything. The SS showed her that the cart was unlocked while residents were coming in and out of the resident lounge and passing by the cart on the unit. The RN verified it should have been locked.		

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NAME OF PROVIDER OR SUPPLIER Canterbury Center		STREET ADDRESS, CITY, STATE, ZIP CODE 80 Maddex Drive Shepherdstown, WV 25443	
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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon record review and staff interview, the facility failed to maintain the accuracy of medical records for its residents. Specifically for wanderguards and their tracking and use. This was discovered during the normal long term survey process and has the ability to affect more than a limited number of residents. Resident identifier: #42. Facility census: 59. Findings included: a) Resident #42 During a record review of Resident #42's chart performed on [DATE] at approximately 12:00 PM, it was discovered that Resident #42 was still wearing a wanderguard (a device that is placed upon a resident who wanders for safety), but the order had expired. The wanderguard orders were set to expire at the end of [DATE]. It was currently [DATE] and the same wanderguard was still on the resident. The orders included a note to Check placement and function daily and note in the medical administration record (MAR). The staff had been making notes in the MAR as checked but this was filed under an area that showed very the expiration. The Director of Nursing (DON) confirmed the wanderguard on the resident was not expired, but the orders were incorrect and had to be updated and they just did that (updated the orders).		

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F 0725 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observations and interviews with residents and staff, the facility failed to ensure proper levels of staff were maintained to provide for the residents' needs. This was discovered during the normal Long Term Survey Process, while meeting with the resident council and has the ability to affect more than a limited number of residents. Census 59. Findings included: a) On 07/14/26 at approximately 10:30 AM during a meeting with the resident council, twelve (12) out of thirteen (13) members in attendance brought up that call light response times are very long. When the group was asked how long they thought the average wait time for a call light to be answered, the response was longer than 45 minutes most days. This was the answer given. This has been an area of note in almost every meeting since the beginning of the year. A second surveyor later confirmed this after overhearing a worker telling a resident, I'm sorry we are short staffed and it's taking so long to get to y'all. In a follow up with the Administrator, they confirmed staffing issues and stated they were working to address these concerns through new hiring and better deployment of current staff.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on observation and interview the facility failed to ensure the daily nursing posting was completed accurately for two (2) days throughout the long-term care survey process. This was a random opportunity for discovery and had the potential to impact more than an isolated number of residents. Facility census: #59. Findings included:a) Staffing dataAn observation of the facility's posted staffing data on 07/12/26 revealed that the required resident census was not documented for 07/11/26 or 07/12/26.During an interview on 07/12/26 at 11:40 AM Registered Nurse (RN) #69 verified the census was not documented. She stated that she would add the census immediately.		