

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365911	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER Winchester Terrace		STREET ADDRESS, CITY, STATE, ZIP CODE 70 Winchester Rd Mansfield, OH 44907	

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 - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on medical record review, staff interview, review of the facility incident and accident log, review of hospital records, review of staff statements, and review of facility policy, the facility failed to ensure staff operated Hoyer lifts in a safe manner to prevent falls. This resulted in Actual Harm on 08/20/25 at approximately 6:30 A.M. when Certified Nursing Assistant (CNA) #236 and Registered Nurse (RN) #252 transferred Resident #03 out of bed with the use of a Hoyer lift and did not ensure the transfer sling straps were secured. During the transfer, the Hoyer lift became stuck and staff forcefully pulled the Hoyer lift, causing the transfer sling strap to disconnect from the lift and Resident #03 fell to the floor. Resident #03 sustained a laceration above the right eyebrow that required sutures, and a laceration to the right wrist. This affected one (Resident #03) of three residents reviewed for falls. The facility census was 46. Findings include: Review of the medical record for Resident #03 revealed an admission date of 04/30/24. Diagnoses included chronic kidney disease, hypertensive heart disease, and venous insufficiency. Review of the significant change Minimum Data Set (MDS) assessment, dated 06/27/25, revealed Resident #03 had severe cognitive impairment and was dependent on staff for transfers and utilized a Hoyer lift. Review of the care plan, dated 06/30/25, revealed Resident #03 had an activities of daily living (ADL) self-care performance deficit and utilized a Hoyer lift and a wheelchair. Interventions included staff to set up equipment and assist as needed for bathing, dressing, and hygiene, monitoring for skin concerns during care, and report all found. Review of the Fall Risk Screen dated 08/20/25 revealed Resident #03 was at high risk for falls and required the use of an assistive device. Review of the facility incident and accident log for August 2025 revealed on 08/20/25 at 6:30 A.M., Resident #03 had a fall in her room. Interventions included emergency room (ER) visit with staff education. Review of the hospital provider notes, dated 08/20/25, revealed Resident #03 presented to the ER at 6:47 A.M. with a chief complaint of a fall and a laceration. Resident #03 had an altered level of mental status, which was chronic, and presented from the nursing home after rolling off a Hoyer lift and falling approximately three feet to the floor. Resident #03 had no loss of consciousness. Resident #03 was awake, alert, and at her baseline, per staff. Resident #03 sustained a two-centimeter (cm) laceration to her right eyebrow, which was repaired with five sutures. Review of the nursing progress note dated 08/20/23 at 12:00 P.M. revealed Resident #03 returned from the hospital with a right forearm open area measuring 1.5 inches (in) by 0.5 in, and right forehead laceration with five sutures. Resident #03 was placed in bed, reoriented to her room and call light, and no other needs were noted. Review of the statement provided by CNA #236, dated 08/20/25, revealed CNA #236 and RN #252 were getting Resident #03 out of bed with the Hoyer lift when CNA #236 thought the wheel of the Hoyer lift had gotten stuck under a cord, but the lift was jammed and began to spin. CNA #236 pulled forward and RN #252 pushed the Hoyer above the chair and the Hoyer pad disconnected, causing the Hoyer lift to stop moving completely. Resident #03 then fell to the floor and hit her head. Review of the statement provided by RN #252, dated 08/20/25 at 2:00 P.M., revealed RN #252 assisted CNA #236 with a Hoyer transfer and the Hoyer became snagged on the wheelchair and bed. When staff attempted to release the Hoyer lift from the snag, the Hoyer strap came off and the resident fell to the floor. Review of the nursing progress note dated 08/25/25 at 11:37 A.M. revealed new orders to clean Resident #03's right forearm skin tear with normal saline and pat dry, apply xeroform and bordered foam three times a week and as needed. During an interview on 09/17/25 at 10:19 A.M., the Director of Nursing (DON) stated CNA #236 and RN #252 were in Resident #03's room to complete a Hoyer lift transfer on 08/20/25. CNA #236 and RN #252 believed the Hoyer lift strap disconnected after they forcefully pulling on the Hoyer lift after it became stuck. The Hoyer lift was immediately pulled from the floor and checked by maintenance, who found no issues with the Hoyer lift. The DON verified Resident #03 sustained a laceration above her right eyebrow that required five sutures and a laceration to the wrist that required wound treatments three times per week. Review of the facility policy titled Activities of Daily Living (ADLs)/ Maintain Abilities, dated 09/03/24, revealed the facility would provide care and services for mobility, transfers and ambulation. The deficiency was corrected on 09/16/25 when the facility implemented the following corrective actions: On 08/20/25 at approximately 6:30 A.M., RN #252 assessed Resident #03 for injury. Resident #03 was transferred to the hospital for further evaluation and treatment. On 08/20/25, Maintenance Director (MD) #244 completed an inspection of all Hoyer lifts, with no concerns identified. Verification was received confirming the inspection was completed. Beginning on</p>		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. (continued on next page)		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, review of electronic mail (e-mail) correspondence, and review of the facility policy, the facility failed to maintain a clean, safe and sanitary environment. This had the potential to affect all 46 residents residing in the facility. The facility census was 46. Findings include: Observation on 09/17/25 at 3:03 P.M. of the courtyard entrance, located near the front doors, revealed a laminate type flooring that was raised and buckled. The flooring was not secured to the floor and could be lifted off of the floor. Further observation revealed spaces between the flooring slats. Observation on 09/17/25 at 3:10 P.M. of the Malabar Lane Hall revealed large areas of discoloration/stains on the carpeting throughout the hallway. Across from Resident # 33's room was a large tear in the carpet, and the carpet was able to be lifted, exposing the floor underneath. Observation on 09/17/25 at 3:15 P.M. of the Oakhill Hall revealed large areas of discoloration/stains on the carpeting throughout the hallway. Further observation revealed a large tear in the carpeting in front of Resident #1's, which exposed the subflooring. Additional observations revealed in front of room [ROOM NUMBER] (unoccupied) the carpeting was lifted from one wall to the other, and in front of room [ROOM NUMBER] (unoccupied) the carpet was lifted. Observation on 09/17/25 at 3:30 P.M. of the Oakhill Circle Hall revealed large areas of discoloration/stains on the carpeting throughout the hallway. Additionally, the carpeting in front of Resident #44 and Resident #20's room had tears, exposing the subfloor. Observation on 09/17/25 at 3:35 P.M. of the [NAME] Court Hall revealed large brown stains and fraying carpet in front of Resident #42 and Resident #41's room. Observation on 09/17/25 at 3:40 P.M. of the [NAME] Avenue Hall revealed the carpeting in front of the therapy and oxygen room had large tears exposing the subfloor and large areas of discoloration/staining was observed throughout the hallway carpeting. Interview on 09/17/25 at 12:30 P.M. with Maintenance Director (MD) #244 revealed that the courtyard drains clogged with mulch from the flower beds anytime there was a hard rain, causing the rainwater to back up into the facility. MD #244 stated the last time water backed-up into the facility was on 08/20/25. MD #244 stated he came to the facility on [DATE] and tried to clean up the water with a floor scrubber and another machine that extracted water. MD #244 stated fans were used to help dry the flooring. MD #244 stated the dining room had a strong musty odor from water and the facility had to close the dining room temporarily until it could dry and air out. MD #244 confirmed the above observations and stated the carpeting throughout the facility needed to be replaced due to tearing, lifting, and fraying in each of the hallways. Interview with the Director of Nursing (DON) on 09/17/25 at 12:15 P.M. revealed the facility had a flooding issue due to the drains in the courtyard backing up. DON stated that FM #600 had been e-mailed on multiple occasions revealing the need for new flooring, with no response received. The DON confirmed that the carpet throughout the facility had tears, lifting, and fraying. The DON also confirmed stains on the carpeting throughout the facility and stated the facility had professional cleaners come to the facility, without improvement. Review of an electronic mail (e-mail) correspondence dated 08/09/25 from the Director of Nursing (DON) to Facility Manager (FM) #600 confirmed the DON identified the following areas of concern that remained following professional carpet cleaning: large stains on the carpet in the lobby entrance, in the hall by room [ROOM NUMBER], in the hall near room [ROOM NUMBER] and 35, in the hall by room [ROOM NUMBER], and in the hall by room [ROOM NUMBER] and 41. Further review revealed the DON identified that new carpet pieces by the dining room were fraying, the carpet at the entrance of the dining room was rippling, the carpet near room [ROOM NUMBER] was fraying, the carpet by room [ROOM NUMBER] was fraying and had white spots, the carpet by room [ROOM NUMBER] had white/light spots and holes present, the carpet by room [ROOM NUMBER] had fraying, and the carpet by room [ROOM NUMBER] and 79 and staining. Lastly, the carpet at the entrance of the soiled laundry room had a large stain. Review of the facility policy titled, Resident Right- Safe/Clean/Comfortable/Homelike Environment, dated 09/03/24, revealed the facility must provide a safe, clean, comfortable, and homelike environment. Review of the facility policy titled, Safe Environment dated 09/03/24, revealed the facility will maintain the facility premises and conducts its operations in a safe and sanitary manor. This deficiency represents non-compliance investigated under Complaint Number 2601158.</p>		