

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 12/31/2025
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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on observation, medical record review, staff interview, and review of the facility policy, the facility failed to ensure mechanical lifts were operated safely. This affected one (#21) of one resident reviewed for mechanical lift transfers. The facility census was 53. Findings include: Review of the medical record for Resident #21 revealed an admission date of 10/23/19. Diagnoses included normal pressure hydrocephalus, hemiplegia, and dementia. Review of the annual Minimum Data Set (MDS) assessment, dated 11/01/25, revealed Resident #21 was cognitively impaired and required total (staff) assistance with Activities of Daily Living (ADLs). Resident #21 utilized a mechanical lift for transfers. Review of the care plan dated 10/23/19 revealed Resident #21 had an ADL deficit related to dementia and hemiplegia. Interventions included using a mechanical lift with two staff to transfer Resident #21 in and out of bed. Review of the physician orders revealed an order dated 12/20/22 for Hoyer (mechanical) lift for all transfers. Observation on 12/30/25 at 11:39 A.M. revealed Certified Nursing Assistant (CNA) #200 entered Resident #21's room with a mechanical lift. No other staff were present. Further observation on 12/30/25 at 11:59 A.M. revealed CNA #200 exited Resident #21's room with the mechanical lift. No other staff were present in the room. Interview on 12/30/25 at 11:59 A.M. with CNA #200 verified she transferred Resident #21 utilizing a mechanical lift without a second staff person present. Further interview with CNA #200 confirmed Resident #21 was to be transferred utilizing a mechanical lift with two staff person assistance. CNA #200 confirmed she was trained on how to transfer a resident utilizing a mechanical lift and knew two staff were to assist with the transfer. Review of the facility policy titled, Hoyer Lift Education-Long Term Care, dated 08/20/25, revealed to always use two staff members when transferring a resident using a mechanical lift. This was an incidental finding discovered during the complaint investigation.</p>

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
-----------------------------------------------------------------------	-------	-----------