

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

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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 06/30/2026
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 ensure the kitchen was maintained in a clean and sanitary manner. This had the potential to affect all 56 residents who consumed food from the kitchen. The facility census was 56. Findings include: Observation on 06/29/26 at 9:15 A.M. revealed the dish room revealed multiple broken and chipped tiles. On the left side, the baseboard was coming away from the wall exposing a large area of wall beneath. Additionally, tiles were coming up under the dishwasher, dishwashing area, and around the drain causing water to pool. There were broken tiles underneath the three-compartment sink and the food preparation sink. Underneath the food preparation sink, the tiles were cracked around the drain and there was standing water. Observed throughout the kitchen, the edges of the walls behind and beneath the kitchen equipment were observed to have food and other debris build up. Interview on 06/29/26 at 9:15 A.M. with [NAME] #162 verified the above observations. [NAME] #162 reported they had been told for a long time that the kitchen floor would be replaced; however, that had yet to occur. Interview on 06/29/26 at 2:16 P.M. with Maintenance Supervisor (MS) #202 revealed the facility was replacing all the floors in the facility in phases; however, he was unsure when the kitchen area would be completed. MS #202 reported he was able to replace tiles and baseboards in the kitchen if he was notified, and verified he was not aware of anything that needed fixed in the kitchen at that moment. Interview on 06/30/26 at 10:35 A.M. with the Administrator revealed they had plans to power wash the kitchen soon to address some of the concerns. This deficiency represents non-compliance investigated under Complaint Number 2717578.		

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, review of pest control visit documents, staff interview, and review of a facility policy, the facility failed to ensure an effective pest control program was provided to eradicate pests in the facility. This had the potential to affect all 56 residents residing in the facility. The census was 56. Findings include: Observation on 06/29/26 at 9:15 A.M. revealed there were numerous flying insects (gnats) in the kitchen, with the highest concentration in the dish room. There were floor tiles coming up under the dishwasher, dishwashing area, and around the drain causing water to pool. Noted underneath the food preparation sink the floor tiles were cracked around the drain and there was standing water. Interview on 06/29/26 at 9:15 A.M. with [NAME] #162 verified the above observations and reported the gnats had gotten better since pest control's last visit. Observation on 06/29/26 at 12:00 P.M. of meal service revealed there were many gnats around the kitchen. Review of the pest control visit dated 05/20/26 revealed Maintenance Supervisor (MS) #202 reported small flies near the dishwasher. Pest control noted some spillage remained under the dishwasher, the area was treated; however, it was noted the area needed cleaned and dried better. Review of the pest control visit dated 05/22/26 revealed the facility had several open conditions that needed addressed. Floor tiles were peeling up under the ice machine and vending machine by the break room the cracks and crevices needed sealed. This problem was first noted on 09/14/23 and listed as high severity. Additionally, it was noted there were floor tiles coming up in the dish room under the dishwasher providing habitat for small flies that was first noted on 09/14/23 and listed as high severity. On 01/28/26 it was noted the facility was told new floors were to be installed. It was also documented there was accumulated spillage noted on or under equipment. The debris and spillage under the dishwasher were present and needed removed or cleaned. This was first noted on 05/15/24 and listed as high severity. Interview on 06/30/26 at 10:35 A.M. with the Administrator revealed they had plans to power wash the kitchen soon to address some of the concerns. The Administrator was unaware pest control had recommended changes to the kitchen for several years. She reported they had a six-phase plan to fix all the floors in the facility, had completed three of the phases, and the kitchen and ice machine area were to be fixed during the fifth phase. The Administrator did not have a timeline for when the phases would be completed. Review of the undated pest control policy revealed the purpose was to ensure a clean and safe environment free of pests and rodents. This deficiency represents non-compliance investigated under Master Complaint Number 2960437, Complaint Number 2736361, and Complaint Number 2717578.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of an medication error investigation, and staff interview, the facility failed to ensure medications were administered to residents as ordered, resulting in a significant medication error. This affected one (#90) of three residents reviewed for medication errors. The census was 56. Findings include: Record review for Resident #90 revealed the resident was admitted to the facility on [DATE] with diagnoses including acute metabolic encephalopathy, chronic pain syndrome, and hypertension. Resident #90 was admitted to the facility directly following her hospitalization for decreased consciousness after taking medication, including Lyrica, a medication used to treat nerve pain. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #90 had intact cognition evidenced by a Brief Interview for Mental Status (BIMS) score of 15. The resident was assessed to require staff assistance with self-care and mobility. Review of the physician's progress notes dated 02/16/26 revealed, at time of admission, Resident #90 brought Lyrica 200 milligram (mg) tablets from home. The physician advised the resident at that time, the Lyrica should be given to the facility staff to hold because, per the resident's discharge instructions from her hospitalization dated 02/13/26, her Lyrica was to be not administered until further notice by the resident's physician. Review of the facility Medication Error Investigation dated 02/18/26 revealed on 02/17/26 at approximately 9:30 A.M., Licensed Practical Nurse (LPN) #215 administered one 200 mg tablet of Lyrica to Resident #90 due to the resident complaining of leg pain. LPN #215, in a written statement, acknowledged the medication was not listed on Resident #90's medication administration report as ordered. When the facility's Director of Nursing (DON) was alerted about the medication error on 02/18/26, the facility's corporate nurse was notified. The facility's Medical Director assessed Resident #90 on 02/18/26 at 11:10 A.M. and found no ill effects. During an interview with the DON on 06/30/26 at 10:35 A.M., she confirmed LPN #215 was terminated for administering Resident #90 Lyrica on 02/17/26 without and order. This deficiency represents non-compliance investigated under Master Complaint Number 2960437.		