

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 07/02/2024
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 0577</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.</p> <p>47990</p> <p>Based on observation, review of survey history, and staff interview, the facility failed to ensure results of complaint investigations by the state survey agency were available as required. This had the potential to affect all 44 residents residing in the facility.</p> <p>Findings include:</p> <p>An observation on 06/30/24 at 12:08 P.M. of the facility's main lobby area revealed a white binder identifying the state survey results. The most recent report contained in the binder was 04/23/23.</p> <p>Review of the previous survey activity for the facility revealed the Ohio Department of Health conducted complaint investigation surveys on 11/03/23, 12/19/23, 02/07/24, and 04/09/24. The results of these surveys were not present in the survey book at the time of the observation on 06/30/24.</p> <p>An interview conducted on 06/30/24 at 1:10 P.M. with the Director of Nursing (DON) verified the survey results binder contained only the results of the last annual survey and were missing the four complaint investigation results reports since the last annual survey. The DON confirmed the survey results books should contain the results of both annual and complaint investigations and stated the book needed to be updated.</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
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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38091</p> <p>Based on record review and staff interview, the facility failed to ensure Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN) contained all the necessary information. This affected two (Residents #6 and #8) of three residents reviewed for beneficiary notices. The facility census was 44.</p> <p>Findings include:</p> <p>1. Review of Resident #6's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including bronchitis, sepsis, and osteoporosis</p> <p>Review of the SNF ABN provided to Resident #6 on 06/14/24 revealed the resident's skilled therapy services were being discontinued due to the resident reaching maximum benefits from therapy services. The notice contained no specific information as to what therapy services were being discontinued and what specific costs the resident would incur if they desired for therapy services to continue. The cost section of the notice was labeled daily cost.</p> <p>Interviewed with the Administrator on 06/30/24 at 3:06 P.M. verified the SNF ABN notice given to Resident #6 did not contain specific information as to what skilled services were ending and information concerning potential costs that would be associated with the resident continuing therapy services</p> <p>2. Review of Resident #8's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including schizophrenia, sepsis and morbid obesity</p> <p>Review of the SNF ABN provided to Resident #8 on 06/26/24 revealed the resident's skilled therapy services were being discontinued due to the resident reaching maximum benefits from therapy services. The notice contained no specific information as to what therapy services were being discontinued and what specific costs the resident would incur if they desired for therapy services to continue. The cost section of the notice was labeled daily cost.</p> <p>Interviewed with the Administrator on 06/30/24 at 3:06 P.M. verified the SNF ABN notice given to Resident #8 did not contain specific information as to what skilled services were ending and information concerning potential costs that would be associated with the resident continuing therapy services</p>		

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<p>F 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>38091</p> <p>Based on record review and staff interview, the facility failed to ensure a representative of the Office of the State Long-Term Care (LTC) Ombudsman were notified of the residents transfers to the hospital. This affected 12 (Residents #14, #21, #40, #41, #42, #43, #145, #146, #147, #148, #149, and #195) reviewed for hospitalization and transfers and had the potential to affect all 44 residents currently residing in the facility.</p> <p>Findings include:</p> <p>Review of the list of admission transfers and discharges from April 2024 through July 2024 revealed the following:</p> <p>Resident #14 was discharged to an acute care hospital on 05/02/24. Resident #21 was discharged to an acute care hospital on 05/03/24. Resident #40 was discharged to an acute care hospital on 04/16/24. Resident #41 was discharged to an acute care hospital on 04/16/24. Resident #42 was discharged to an acute care hospital on 05/20/24. Resident #43 was discharged to an acute care hospital on 05/07/24. Resident #145 was discharged to an acute care hospital on 06/12/24. Resident #146 was discharged to an acute care hospital on 05/22/24. Resident #147 was discharged to an acute care hospital on 06/27/24. Resident #148 was discharged to an acute care hospital on 06/29/24. Resident #149 was discharged to an acute care hospital on 04/05/24. Resident #195 was discharged to an acute care hospital on 06/28/24.</p> <p>Review of the medical records for Residents #14, #21, #40, #41, #42, #43, #145, #146, #147, #148, #149, and #195 revealed there were no evidence in their medical record that the LTC Ombudsman was notified of their transfer to a hospital as required.</p> <p>Interview with the Administrator on 07/01/24 at 1:34 P.M. verified the facility did not notify the LTC Ombudsman of any resident transfers to the hospital as required. The Administrator stated notifying the LTC Ombudsman of resident transfers to the hospital had fallen through the cracks, unfortunately.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47990</p> <p>Based on observations, staff, resident and family interviews, record review, and policy review, the facility failed to offer or provide Resident #194, who was dependent on staff for hygiene tasks, assistance with shaving. This affected one (Resident #194) of three residents reviewed for activities of daily living (ADL). The facility census was 44.</p> <p>Findings include:</p> <p>Review of Resident #194's medical record revealed an admitted [DATE]. Diagnoses included malignant neoplasm of the pancreatic duct, type II diabetes mellitus, vertigo, and weakness.</p> <p>Review of Resident #194's admission nursing assessment, dated 06/26/24, revealed the resident was identified to be dependent on staff for bathing, dressing, and hygiene tasks.</p> <p>Review of Resident #194's care plan, revised 07/02/24, revealed the resident had an ADL self-care performance deficit related to an acute illness, impaired mobility, weakness, and history of falls. The resident was identified to require assistance with bathing, hygiene, transfers, toileting, ambulating, and dressing. Listed interventions included Resident #194 required staff assistance to complete bathing, hygiene, and dressing tasks.</p> <p>An observation and interview on 06/30/24 at 9:08 A.M. with Resident #194 and a family member of Resident #194 revealed the resident had unkempt facial hair approximately one quarter inch long. The resident was observed rubbing his face and cheeks and stated he preferred to be clean shaven. The family member of Resident #194 confirmed the resident preferred to be clean shaven and had brought in his personal electric razor, but no staff members had offered to shave him.</p> <p>A subsequent observation on 07/01/24 at 10:10 A.M. of Resident #194 revealed the resident seated in his recliner chair in his room. The resident remained unkempt and unshaved, with the facial hair unchanged from the prior observation.</p> <p>An interview on 07/01/24 at 4:25 P.M. with Licensed Practical Nurse (LPN) #404 confirmed Resident #194 required hands-on assistance with ADLs. LPN #404 confirmed the aides should be completing hygiene tasks on a daily basis, and morning care should consist of changing clothes and shaving male residents if preferred. LPN #404 stated the aides were a good crew, but required reminders to offer and complete certain tasks, such as shaving male residents.</p> <p>An interview on 07/01/24 at 4:52 P.M. with State tested Nurse Aide (STNA) #412 revealed she was assigned to care for Resident #194 from 7:00 A.M. to 7:00 P.M. STNA #412 stated she was unaware of the resident's preferences for shaving. STNA #412 confirmed she had seen shaving supplies in the resident's room that day but verified she did not offer to assist him with shaving.</p> <p>An observation on 07/02/24 at 7:17 A.M. of Resident #194 with the Director of Nursing (DON) revealed the resident was lying in bed. The resident's facial hair appeared unchanged from prior observations, approximately one quarter inch in length. The DON confirmed the resident was unshaved and described him as scruffy and stated he would be offered to be shaved today.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the policy titled Activities of Daily Living (ADLs)/Maintain Abilities, undated, revealed it is the policy of the facility to create and sustain an environment that humanizes and individualizes each resident's quality of life. The policy specified care and services provided are person-centered and honor and support each resident's preferences, choices, values, and beliefs. The facility will provide care and services which included hygiene tasks of bathing, dressing, grooming and oral care. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47990</p> <p>Based on observation, staff, family, and resident interview, record review, and policy review, the facility failed to provide a program of activities that met the needs and preferences of the residents. This affected three (Residents #3, #8, and #41) of four residents reviewed for activities. The facility census was 44.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #41 revealed an admitted [DATE]. Medical diagnoses included coronary artery disease, atrial fibrillation, and had a fall resulting in a left femur fracture prior to admission to the facility. The record identified Resident #41 had elected to receive hospice services.</p> <p>Review of Resident #41's Minimum Data Set (MDS) 3.0 significant change in status assessment, dated [DATE], revealed the resident had severely impaired cognition. The resident's activity section revealed the resident was interviewed as to activity preferences, and listed having family members involved in her care as very important, and having books and magazines to read and doing her favorite activities as somewhat important.</p> <p>Review of Resident #41's care plan, dated revised [DATE] revealed the resident had a cognitive deficit and the potential for activity or psychosocial deficit. A listed intervention included to engage the resident in simple, structured activities that avoided overly demanding tasks.</p> <p>Review of Resident #41's activity documentation in the electronic medical record under tasks from [DATE] to [DATE] revealed options for staff to record activity attendance and participation at various types of activities which included music, television, radio, family/friend visits, chaplain visits, and room visits. Resident #41's record contained only five entries of Resident #41 receiving any types of activities. These entries, recorded on, [DATE], [DATE], [DATE], [DATE] and [DATE], indicated the resident received family/friend visits and were documented by State tested Nurse Aide (STNA) #412. There was no entries recorded by any activity staff members.</p> <p>Review of Resident #41's interdisciplinary progress notes from [DATE] to [DATE] revealed no indication the resident had been invited to participate in activities, screened for activity preferences, or had any 1:1 room visits, outside of family and friend visits, recorded.</p> <p>An interview on [DATE] at 10:43 A.M. with a family member of Resident #41 revealed the resident had recently declined and was receiving hospice care. Resident #41 was previously more alert and able bodied . The family member identified she visits near-daily and revealed staff had not offered or provided any way for Resident #41 to continue to participate in activities she enjoyed. The family member explained the resident had always enjoyed music, specifically country music, but the facility did not have the television channel that played country music.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on [DATE] at 3:21 P.M. with Activity Director (AD) #411 revealed she had been at the facility for approximately one year and knew the residents fairly well. AD #411 confirmed she works Monday through Friday during daytime hours, and was the only activity personnel employed by the facility. AD #411 stated Resident #41 slept a lot and was unsure if she enjoyed music. AD #411 stated she had not talked to the family of Resident #41 to obtain preferences and likes, and had never arranged for or provided music for Resident #41. AD #411 stated she records activity participation in each resident's electronic medical record which would be available under tasks. A review of Resident #41's activity documentation with AD #411 confirmed she did not record any documentation of activities or attempts for Resident #41 for the past 30 days. AD #411 confirmed that even though Resident #41 was mostly in bed, she does not provide any 1:1 or room visits for this resident.</p> <p>38523</p> <p>2. Review of the record revealed Resident #3 was admitted to the facility on [DATE] with diagnoses including Charcot [NAME] Tooth disorder, hereditary motor and sensory neuropathy, and bicipital tendinitis of the left shoulder.</p> <p>Review of Resident #3's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed she was cognitively intact. She had impairment of both sides of her upper and lower extremities. She used an electric wheelchair. She was dependent on staff for all activities of daily living.</p> <p>Review of Resident #3's record revealed no activity documentation, activity progress or activity summary notes were found for the past 30 days.</p> <p>An interview on [DATE] at 9:12 A.M. with Resident #3 revealed the resident never goes to activities because they do activities she cannot physically do, as they involve using her extremities which she was unable to do. Resident #3 stated sometimes the facility canceled the few activities she did enjoy, such as the once-monthly happy hour.</p> <p>Review of Resident #3's activity documentation with Activity Director (AD) #411 on [DATE] at 3:21 P.M. confirmed she did not record any documentation of activities or attempts for Resident #3 in the past 30 days.</p> <p>3. Review of the record revealed Resident #8 was admitted to the facility on [DATE] with diagnoses including sepsis due to Escherichia Coli (E. Coli), rheumatoid arthritis, and osteoarthritis.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #8 has intact cognition.</p> <p>Review of Resident #8's care plan revealed the resident was very active in activities and enjoyed BINGO, cratfing, and cooking activities. Interventions included Resident #8 will attend/participate in activities of choice three to five times per day and invite the resident to scheduled activities.</p> <p>Review of Resident #8's record revealed no activity documentation, activity progress or activity summary notes were found.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on [DATE] at 9:37 A.M. with Resident #8 revealed the facility had no activities in the evenings or weekends. There was only one activity staff person, and she works Monday through Friday, only on day shift.</p> <p>An interview on [DATE] at 3:21 P.M. with Activity Director (AD) #411 confirmed she did not record any documentation of activities or attempts for Resident #8 in the past 30 days. AD #411 stated she works Monday through Friday during daytime hours, and was the only activity staff member employed by the facility. AD #411 stated the facility does not offer evening activities and all the residents went to bed right after dinner. AD #411 confirmed she had to cancel certain activities, including the [DATE] happy hour, as she did not receive her monthly budget for that month and had nothing to provide to the residents. AD #411 confirmed there was no designated activity personnel for the weekends, and she believed the STNAs were responsible for completing weekend activities in her absence.</p> <p>Review of the facility policy titled Activities Meet Interest/Needs of Each Resident dated [DATE] revealed it is the facility's responsibility to create and sustain an environment that humanizes and individualizes each resident's quality of life by ensuring all staff, across all shifts and departments, understand the principles of quality of life and honor and support these principles for each resident and that the care and services provided are person-centered and honor and support each resident's preferences, choices, values and beliefs.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38523</p> <p>Based on observation, staff interviews, medical record review, review of the Centers for Disease Control and Prevention (CDC) guidance on prevention of Catheter-Associated Urinary Tract Infections, and review of the facility policy, the facility failed to ensure residents urinary catheter bags were not resting on the floor. This affected two (Residents #20 and #28) of seven residents with urinary catheters. The facility census was 44.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #28 revealed an admitted [DATE]. Diagnoses included personal history of urinary tract infections, hydronephrosis with renal and ureteral calculous obstruction and presence of urogenital implants (suprapubic catheter).</p> <p>Review of Resident #28's care plan, undated, revealed the resident was at risk for complications related to her suprapubic catheter. The resident required the use of a suprapubic catheter related to obstructive and reflux uropathy. Listed interventions included to not allow the urinary drainage bag to lie on the floor.</p> <p>Observation on 06/30/24 at 9:46 A.M. revealed Resident #28's catheter bag was hung on the trash can and resting on the floor.</p> <p>Interview on 06/30/24 at 9:54 A.M. with Registered Nurse (RN) #444 verified the catheter bag was hooked on the trash can and resting on the floor. The catheter tubing was caught in the footrest of the recliner she was sitting in.</p> <p>2. Review of Resident #20's medical record revealed an admitted [DATE]. Medical diagnoses included neuromuscular dysfunction of the bladder and chronic kidney disease.</p> <p>Review of Resident #20's care plan, undated, revealed the resident was at risk for complications related to the use of a Foley (indwelling urinary) catheter. Listed interventions included to provide catheter care every shift and to not allow the urinary drainage bag to lie on the floor.</p> <p>Observation on 06/30/24 at 10:15 A.M. revealed Resident #20's indwelling urinary catheter bag was resting on the floor.</p> <p>Interview on 06/30/24 at 10:15 A.M. with Agency Licensed Practical Nurse (LPN) #450 confirmed the above observation.</p> <p>An interview on 07/02/24 at 10:58 A.M. with the Director of Nursing (DON) confirmed she connected binder-type clips to catheter tubing so they can be more easily secured and will not drag on the floor.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the policy titled Infection Prevention and Control and Surveillance Program, dated 10/2023, revealed the infection control program is designed to prevent, report, investigate and control the spread of infections and communicable disease for all residents; provide a safe, sanitary, and comfortable environment; and to help prevent the development and transmission of disease and infection.</p> <p>Review of the CDC's Summary of Recommendations from the Guidelines for Prevention of Catheter-Associated Urinary Tract Infections, last updated 03/25/24, and found out at https://www.cdc.gov/infection-control/hcp/cauti/summary-of-recommendations.html revealed to keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor.</p>		

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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>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>38091</p> <p>Based on observation and staff interview, the facility failed to ensure carpeting was maintained in a clean, sanitary and safe condition. This had the potential to affect all 44 residents residing in the facility.</p> <p>Findings Include:</p> <p>1. Random intermittent observations on 06/30/24 between 8:00 A.M. and 4:00 P.M. revealed large numerous areas of stains on the carpeting through out the facility. Numerous instances of carpet peeling, creating a tripping hazard, were also noted through out the facility.</p> <p>Interview with the Administrator on 07/01/24 at 1:34 P.M. verified the condition of carpeting. The Administrator further stated areas (of the carpeting) were just replaced approximately six months ago. At this point in time, I do not believe it is in the budget to replace.</p> <p>2. Observation of the dinning room sink on 07/02/24 at 12:00 P.M. revealed significant areas of brown and black discoloration in the sink and around the drain. When wiped with a towel, a thick brown layer of what appeared to be a mixture of brown and black sludge was taken off but the discoloration in the drain and sink remained</p> <p>The Administrator verified the condition of the sink and drain in an interview on 07/02/24 at 12:00 P.M.</p>		