STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366016	A. Building B. Wing	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Main Street Terrace Care Center	1318 E Main Street Lancaster, OH 43130

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37100 Based on medical record review and staff interview the facility failed to notify the physician of significant weight changes for a resident with congestive heart failure and failed to notify the physician of abnormal urinalysis results. This affected two (Residents #38 and #46) of 15 residents sampled. The facility census was 49 residents. Findings include: 1.Review of the medical record for Resident #38 revealed an admitted [DATE] with diagnoses including acute respiratory failure with hypoxia, morbid obesity, and congestive heart failure. Review of the care plan for Resident #38 initiated 04/10/24 revealed the resident had a potential for fluid volume deficit related to diuretic use. Interventions included to monitor and document the resident's weight and report weight changes to the physician. Review of the weight record for Resident #38 revealed the resident weighed 289 pounds (lbs) on 04/10/24 and on 04/17/24 the resident weighed 294.8 lbs. Review of the weight record for Resident #38 revealed on 05/07/24 the resident weighed 304 lbs. and on 05/17/24 the resident weighed 296.4 lbs. Review of the weight record for Resident #38 revealed on 06/04/24 the resident weighed 309.4 lbs. and on 06/11/24 the resident weighed 302 lbs. Review of the weight record for Resident #38 revealed on 07/11/24 the resident weighed 303.2 lbs. and on 08/02/24 the resident weight 313.6 lbs. Review of the weight record for Resident #38 revealed on 08/02/24 the resident weighed 313.6 lbs. and on 09/04/24 the resident weighed 301.5 lbs. Review of the progress notes for Resident #38 dated 04/10/24 to 09/04/24 revealed the notes did not include documentation of physician notification of the resident's weight fluctuations. Review of the Minimum Data Set (MDS) assessment for Resident #38 dated 08/29/24 revealed the resident was cognitively intact. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/23/24 at 7:49 A.M. with Director of Nursing (DON) confirmed Resident #38's weight fluctuations had not been reported to the resident's attending physician. Interview with the DON further confirmed Resident #38's weight changes should be reported to the physician particularly due to the resident's diuretic use and diagnosis of congestive heart failure. 50536 2. Review of the medical record for Resident #46 revealed an admitted [DATE] with diagnoses including metabolic encephalopathy, type two diabetes, obstructive uropathy, and benign prostatic hypertrophy (BPH.) Review of the care plan for Resident #46 initiated 02/07/24 revealed the resident had the potential for infection related to the presence of an indwelling urinary catheter. Interventions included to monitor lab results by obtaining urinalysis, culture, and sensitivity specimens for testing per physician's order, and reporting results to the physician. Review of a laboratory report for Resident #46 dated 07/25/24 revealed the urinalysis was abnormal and indicated a level greater than 100,000 mixed pathogens and was probably a contaminated sample. Review of the progress notes for Resident #46 for July 2024 revealed they did not include notification to the physician of the abnormal urinalysis result dated 07/25/24. Interview on 10/23/24 at 9:38 A.M. with Registered Nurse (RN) #18 confirmed Resident #46 had abnormal urinalysis test resulted on 07/25/24 and the facility failed to notify the resident's physician.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on medical record review, staff interview and review of the facility policy, the facility failed to complete comprehensive resident care plans. This affected four (Residents #9, # 15, #18, and #20) of 15 residents sampled. The facility census was 49 residents. Findings include: 1.Review of the medical record for Resident #18 revealed an admitted [DATE] with diagnoses including hemiplegia and hemiparesis affecting right dominant side, major depressive disorder, dysphagia, aphasia, Parkinson's disease, and anxiety disorder. Review of the care plan for Resident #18 initiated 01/06/18 revealed it did not include a care plan for wandering, exit-seeking, or high risk for elopement. Review of the physician's orders for Resident #18 revealed an order dated 07/01/24 revealed for a Wanderguard to the right ankle for exit seeking. Review of the progress note for Resident #18 dated 07/01/24 revealed the resident had been attempting to exit seek out of the doors and a new order for a Wanderguard was received. Review of the progress notes for Resident #18 dated 08/31/24 and 09/03/24 revealed the resident was exit seeking but was redirected by staff. Review of the Minimum Data Set (MDS) assessment for Resident #18 dated 09/05/24 revealed the resident had severely impaired cognition and was coded for the presence of wandering during one to three days of the review period. Review of the progress notes for Resident #18 dated 09/28/24, 10/08/24, and 10/11/24 revealed the resident was wandering, but was redirected by staff. Interview on 10/23/24 at 7:47 A.M. with the Director of Nursing (DON) confirmed Resident #18's care plan did not address the resident's risk for elopement and/or wandering and exit-seeking behaviors. 2. Review of the medical record for Resident #15's medical revealed an admitted [DATE] with diagnoses including dementia, expressive language disorder, major depressive disorder, gastro-esophageal disease, and chronic kidney disease. Review of the care plan for Resident #15 initiated 08/10/23 revealed it did not include a care plan for use of TED hose and/or a care plan for activities. Review of the physician's orders for Resident #15 revealed an order dated 03/15/24 for TED hose to be applied in the morning and removed at bedtime. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MDS assessment for Resident #15 dated 07/25/24 revealed the resident had impaired cognition. Review of the activity assessment for Resident #15 dated 09/20/24 revealed the resident felt it was somewhat important for her to read and it was very important for her to listen to music, see animals, keep up with the news, participate in groups, do her favorite activities, go outside when the weather is good, and participate in religious services. Interview on 10/23/24 at 2:00 P.M. with the DON confirmed Resident #15's TED hose were not addressed in the plan of care. Interview on 10/23/24 at 2:40 P.M. with Activities Director (AD) #45 confirmed Social Services Director (SSD) #15 had been completing the activity care plans for the residents. Interview on 10/23/24 at 2:43 P.M. with SSD #15 confirmed there was no activity care plan for Resident #15. 32654 3. Review of the medical record for Resident #20 revealed an admitted [DATE] with diagnoses including congestive heart failure, chronic kidney disease, major depressive disorder, chronic obstructive pulmonary disease, depression, atrial fibrillation and chronic respiratory failure with hypercapnia. Review of the MDS assessment for Resident #20 dated 08/30/24 revealed the resident had a moderate cognitive deficit and received oxygen. Review of physician's orders for Resident #20 revealed an order dated 01/11/23 for oxygen at two liters per nasal cannula to keep oxygen saturation above 90 percent (%) as needed for shortness of breath and to change oxygen tubing and water weekly. Review of the care plan for Resident #20 initiated 12/14/22 revealed it did not include a care plan which addressed the resident's use of supplemental oxygen. Interview on 10/22/24 at 10:49 A.M. with Registered Nurse (RN) #18 confirmed Resident #20 the facility had not developed a care plan regarding the resident's supplemental oxygen use as ordered by the physician. 4. Review of the medical record for Resident # 9 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease, diabetes mellitus (DM), osteoarthritis, osteoporosis, anemia, dysphagia, anxiety disorder, major depressive disorder, Parkinson's disease, hypertension, and congestive heart failure. Review of the care plan for Resident #9 initiated 03/05/24 revealed the care plan did not address the resident's DM diagnosis and/or the resident's use of daily insulin. Review of the MDS assessment for Resident #9 dated 09/07/24 revealed the resident had no cognitive deficit, had DM as a current diagnosis, and received daily insulin injections. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 10/22/24 at 4:35 P.M. with Licensed Practical Nurse (LPN) #14 confirmed Resident #9's care plan did not address the resident's DM diagnosis, nor did it address the resident's daily use of insulin. Review of the facility policy titled Comprehensive Person-Centered Care Plans dated March 2022 revealed the facility should develop and implement a comprehensive person-centered care plan for each resident that included measurable goals and timetables to meet the resident's physical, psychosocial and functional needs.

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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** 37100 Based on medical record review, family interview, and staff interview, the facility failed to assist all dependent residents with oral hygiene. This affected one (Resident #22) of one residents reviewed for activities of daily living (ADL) care. The facility census was 49 residents. Findings include: Review of the medical record for Resident #22 revealed an admitted [DATE] with diagnoses including dementia, major depressive disorder, type two diabetes, atherosclerotic heart disease, hypertension, and hypothyroidism. Review of the care plan for Resident #22 initiated 06/01/23 revealed the resident required the assistance of one staff with personal hygiene and oral care. Review of the Minimum Data Set (MDS) assessment for Resident #22 dated 08/16/24 revealed the resident had mild cognitive impairment and was to receive supervision/touching assistance with oral care. Review of the physician's orders for Resident #22 revealed an order dated 10/01/24 for denture care completed after each meal and at bedtime. The dentures were to be cleaned with a denture brush and antibacterial soap, four times daily. Review of the ADL Task Log for Resident #22 dated 10/01/24 to 10/22/24 revealed the resident had a total of 88 opportunities that staff were to assist with denture care. Of those 88 opportunities for denture care, there were only 43 times that the resident's dentures were documented as being cleaned. Resident #22 was not interviewable. Interview on 10/21/24 at 12:16 P.M. with Resident #22's representative confirmed they had to speak with the facility management because the resident's dentures were not not always clean when they came to visit. Interview on 10/24/24 at 9:46 A.M. with State tested Nurse Aide (STNA) #8 confirmed the aides recorded ADL care on the ADL Task Log in the electronic medical record. STNA #8 confirmed if Resident #22's denture care was not signed off in the ADL Task Log it wasn't done. Interview on 10/24/24 at 9:57 A.M. with Director of Nursing (DON) confirmed the ADL Task Log in the electronic medical record would be the only location in which ADL care was documented. The DON confirmed the facility had no documentation that staff cleaned Resident #22's dentures four times daily as ordered.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on medical record review, staff interview, and observation, the facility failed to perform regular resident blood pressure checks and failed to apply thromboembolic deterrent (TED) hose as ordered. This affected two (Resident #38 and #29) of 15 residents sampled. The facility census was 49 residents. Findings include: 1. Review of the medical record for Resident #38 revealed an admitted [DATE] with diagnoses including acute respiratory failure with hypoxia, hypertension, morbid obesity, and congestive heart failure. Review of the monthly physician's orders for Resident #38 revealed an order dated 06/12/24 for lisinopril (an anti-hypertensive medication) 2.5 milligrams (mg) once daily and an order dated 06/12/24 for spironolactone (a diuretic medication), and an order dated 10/06/24 to take full vital signs on a monthly basis, which included measuring blood pressure. Review of the vital sign records for Resident #38 dated 04/14/24 to 10/08/24 revealed monthly blood pressure checks were not completed in June, July, and August of 2024. There were no blood pressures completed from 05/10/24 to 09/10/24. Interview on 10/23/24 at 7:49 A.M. with the Director of Nursing (DON) confirmed the facility should have checked Resident #38's blood pressure at least monthly at a minimum but they had not checked the resident's blood pressure from 05/10/24 to 09/10/24. 2. Review of the medical record for Resident #29 revealed an admitted [DATE] with diagnoses including Parkinson's disease, major depressive disorder, schizophrenia, depression, respiratory disorders, dysphagia, and hypertension. Review of the physician's orders for Resident #29 revealed an order dated 05/03/23 for the resident to have TED hose on in the morning and off at bedtime. Review of the care plan for Resident #29 dated 04/24/24 revealed the resident had impaired breathing problems and altered cardiac output related to atrioventricular block, bradycardia, hypertension, atrial fibrillation, asthma, and shortness of breath with exertion and sitting at rest at times. Interventions included the following: administer medications as ordered, allowing resident to perform activity at own rate, encourage fluid intake, labs as ordered, TED hose to lower bilateral extremities on in morning and off at bedtime. Review of the Minimum Data Set (MDS) assessment for Resident #29 dated 07/24/24 revealed the resident had intact cognition. Review of the Medication Administration Record (MAR) for Resident #29 revealed the MAR dated 10/22/24 was marked to indicate the resident's TED hose were in place. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations on 10/21/24 at 11:43 A.M. and on 10/22/24 at 3:09 P.M. and 3:37 P.M. revealed Resident #29 did not have TED hose in place. Interview on 10/22/24 at 3:37 P.M. with State tested Nursing Aide (STNA) #7 confirmed Resident #29 was not wearing her TED hose and had refused to wear them for a long time. STNA #7 could not recall the last time the resident wore the TED hose. Interview on 10/22/24 at 3:41 P.M. with Licensed Practical Nurse (LPN) #5 confirmed Resident #29 had a physician's order for TED hose, and she had marked Resident #29's MAR to indicate the resident was wearing the TED hose, but the resident was not wearing them.

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	366016	A. Building B. Wing	10/28/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47987 Based on medical record review, review of the facility policy, review of information from the National Pressure Ulcer Advisory Panel (NPUAP) and interview, the facility failed to develop and implement a comprehensive and individualized pressure ulcer program to prevent the deterioration of a pressure ulcer for Resident #45. Actual Harm occurred on 10/03/24 when Resident #45, who was admitted to the facility with a Stage III (full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present) sacral pressure ulcer was assessed to have an unstageable (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar) pressure ulcer with the presence of slough and necrotic tissue to the area. The deterioration of the pressure ulcer was a result of the facility not implementing effective and timely treatment. This affected one resident (#45) of one resident reviewed for pressure ulcers. The facility census was 49 residents. Findings include: Review of the medical record for Resident #45 revealed an admitted [DATE] with diagnoses including cerebral infarction, encounter for surgical aftercare following surgery on the digestive system, hemiplegia and hemiparesis, and history of pulmonary embolism. Review of the baseline care plan for Resident #45 dated 09/25/24 revealed the resident had a stage III pressure ulcer to the sacrum with the intervention to provide wound care/treatment per physician order. Review of the monthly physician's orders for Resident #45 revealed an order dated 09/25/24 to apply house barrier cream to buttocks and peri area every shift. Review of the pressure ulcer risk assessment for Resident #45 dated 09/26/24 revealed the resident was at high risk for skin breakdown. Review of the admission assessment for Resident #45 dated 09/26/24 revealed the resident had a Stage III pressure ulcer to the sacrum which measured 5.0 centimeters (cm) length by 5.0 cm width with 0.1 in depth with a scant amount of sanguineous (bloody) drainage and a pink, healthy wound bed. There was no dressing or wound treatment ordered for the pressure ulcer. The resident only had an order to apply house barrier cream to the buttocks and peri area. Review of the Minimum Data Set (MDS) assessment for Resident #45 dated 10/01/24 revealed the resident was cognitively intact, was totally dependent on staff for bathing, hygiene, bed mobility, and transfers, and was coded for the presence of stage III pressure ulcer upon admission to the facility. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the weekly skin assessment for Resident #45 dated 10/03/24 revealed the resident's pressure ulcer to the sacrum was now classified as an unstageable pressure ulcer and measured 4.8 cm length by 3.0 cm width with 0.2 cm in depth with a moderate amount of sanguineous drainage and the presence of slough wound bed. The new treatment order was to cleanse the wound with normal saline and apply Mesalt and a dry dressing to the wound bed. Review of the wound physician note for Resident #45 per Wound Physician (WP) #81 dated 10/03/24 revealed the resident had an unstageable (due to necrosis) sacral full thickness pressure ulcer which measured 4.8 cm length by 3.0 cm width with 0.2 cm in depth with a moderate amount of serous exudate, 20 percent (%) thick adherent devitalized necrotic tissue and 30 % slough (yellow/white material which consists of dead cells that accumulate in the wound bed). The new treatment order was to cleanse the wound with normal saline, apply Mesalt, and cover with a dry dressing. Review of the monthly physician's orders for Resident #45 revealed an order dated 10/03/24 to cleanse the sacral wound with normal saline, apply Mesalt, and cover with a dry dressing daily and as needed. Interview on 10/22/24 at 11:41 AM with the Resident #45 confirmed she had a pressure ulcer to her sacrum which required daily wound care. At the time of the interview, Resident #45 declined observation of wound care because the wound was located on the sacrum/buttocks area. Interview on 10/22/24 at 3:19 P.M. with the Director of Nursing (DON) confirmed Resident #45 was admitted with a Stage III pressure ulcer to the sacrum on 09/25/24. The DON confirmed the facility nurse did not contact the physician to obtain an appropriate treatment order, and the wound was noted to have worsened/deteriorated on 10/03/24 to an unstageable pressure ulcer with the presence of slough and necrotic tissue. Interview on 10/22/24 at 4:09 P.M. with the Assistant Director of Nursing (ADON) revealed she completed the wound assessment for Resident #45 on 09/26/24 and she did not contact the physician to obtain an appropriate treatment order for the resident's sacral ulcer which she had classified as a Stage III upon admission. The ADON confirmed there was no order implemented upon admission to cleanse Resident #45's pressure ulcer and/or to apply a treatment to promote wound healing and a dressing to cover the wound. Interview on 10/23/24 at 9:56 A.M. with State tested Nursing Assistant (STNA) #7 revealed if a resident had a pressure ulcer, she would not apply house barrier cream to the ulcer but would notify the nurse so the nurse could assess the wound and see if it needed a dressing and/or a treatment to be done by the nurses. Interview on 10/23/24 at 10:05 A.M. with Registered Nurse (RN) #1 revealed she completed skin assessments on residents admitted to the facility over the weekends and after hours. RN #1 confirmed she was able to stage pressure ulcer injuries and utilized the resources provided in the medication room which included a staging chart. RN #1 revealed she reviewed the wound measurements and descriptions for Resident #45's admission skin assessment dated [DATE] and verified she would have staged the resident's wound as a Stage III pressure ulcer on 09/26/24, but she then would have notified the physician for an appropriate treatment to promote healing of the wound. RN #1 confirmed house barrier cream was not an appropriate wound treatment for a Stage III pressure ulcer. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview on 10/24/24 at 6:46 A.M. via telephone with WP #81 revealed he would have ordered triad hydrophilic for Resident #45's Stage III pressure ulcer upon admission, and house barrier cream utilized by the facility was not an appropriate treatment order. WP #81 further confirmed when he first saw the wound on 10/03/24, it presented as unstageable pressure ulcer with slough and necrotic tissue and he ordered a more aggressive treatment, cleanse with normal saline, apply Mesalt, and cover with a dry dressing, because the wound had worsened. Review of the facility undated policy titled Skin Protocol revealed house barrier cream would be used as a preventative measure on the buttocks or peri area to prevent rashes or excoriation due to incontinence. Staff should contact the wound physician for wound orders and treatment for actual pressure ulcers. Review of online information from the NPUAP at chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://cdn.ymaws.com/npiap.com/resource/resmgr/2014_guideline.pdf on 10/28/24 on page 93 revealed the facility staff should implement treatments to prevent contamination of the pressure ulcer. Pressure ulcers near the anus were subject to contamination, especially by bacteria from the colon. Meticulous skin cleansing and use of dressings or topical agents to prevent exposure to fecal matter were needed. Further review on page 588 revealed wound dressings were a central component of pressure ulcer care and wound healing was optimized when the wound was kept in a moist environment. Occlusive or semi-occlusive wound dressings that maintained wound bed moisture promoted re-epithelialization and wound closure. Wound dressings for pressure ulcers would improve wound healing time, absorb blood and tissue exudate, minimize pain associated with application and removal, absorb and control malodor, reduce injury to periwound skin.

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	366016	A. Building B. Wing	10/28/2024

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on medical record review, staff interview, and review of the facility policy, the facility failed to assess residents for elopement risk. Additionally, the facility failed to ensure residents were properly supervised to prevent falls. This affected two (Residents #15 and #20) of six residents reviewed for accidents. The facility census was 49 residents. Findings include: 1.Review of the medical record for Resident #15 revealed an admitted [DATE] with diagnoses including dementia, expressive language disorder, major depressive disorder, gastro-esophageal disease, and chronic kidney disease. Review of the care plan for Resident #15 initiated 08/10/13 revealed it did not include the resident's risk for elopement or wandering behaviors. Review of the Minimum Data Set (MDS) assessment for Resident #15 dated 07/25/24 revealed the resident had impaired cognition and had no wandering behaviors during the review period. Review of the progress note for Resident #15 dated 10/08/24 revealed the resident had increased confusion and was standing by exit doors. Staff redirected the resident back to her room and new orders were obtained for a Wanderguard to the right ankle due to exit seeking. Review of the physician's orders for Resident #15 revealed an order dated 10/08/24 for Wanderguard bracelet to the right ankle. Review of the medical record for Resident #15 revealed it did not include an assessment of the resident's risk for elopement. Interview on 10/23/24 at 8:34 A.M. with the Director of Nursing (DON) confirmed elopement risk assessments should be completed upon admission, quarterly, and with significant changes for all residents. The DON further confirmed the facility had not completed an elopement risk assessment for Resident #15 and the resident had exhibited recent exit-seeking behavior. Review of the facility policy titled Elopement undated revealed the facility would maintain the safety of all residents, minimize the potential of residents eloping from the facility, would determine which residents were at risk for elopement, and would prevent reoccurring elopements. The facility would assess all residents for elopement upon admission, quarterly, and with any significant changes. 32654 2. Review of the medical record for Resident #20 revealed an admitted [DATE] with diagnoses including congestive heart failure, chronic kidney disease, and hypertensive heart disease. (continued on next page)

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	366016	A. Building B. Wing	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Main Street Terrace Care Center	1318 E Main Street Lancaster, OH 43130

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan for Resident #20 dated 03/12/24 revealed the resident had the potential for falls related to balance deficit, history of falls and noncompliance. Interventions included the following: half side rails to enhance independent bed mobility, assist in position for comfort as needed, anticipate needs as able, bed against wall, Dycem to reclining chair on top and under the pad to decrease the risk of sliding off seat, encourage non-skid footwear at all times, encourage to ask/use call light for assistance, call light within reach, low bed in low position while occupied, maintain uncluttered environment, mat to floor bedside bed, pressure alarm to chair to remind resident of need for assistance and alert staff resident may need assistance. Review of the Minimum Data Set (MDS) assessment for Resident #20 dated 08/30/24 revealed the resident had a moderate cognitive deficit. Review of the fall risk evaluation for Resident #20 dated 09/23/24 revealed the resident was at risk for falls. Review of the late entry progress note for Resident #20 dated 09/27/24 timed at 6:38 P.M. revealed on 09/23/24 at 10:00 A.M. a State tested Nursing Assistant (STNA) notified the nurse the resident was on the floor in the shower room. Review of the Interdisciplinary Team (IDT) progress note for Resident #20 dated 09/30/24 at 9:38 A.M. revealed the fall on 09/23/24 occurred in the shower room when STNA #28 took Resident #20 into the shower room, transferred the resident to the commode and then left the shower room. Resident #20 stated she fell when trying to transfer herself off the commode. Resident #20 sustained no injuries and all staff were reeducated that residents cannot be left in the shower room without a staff member present. Interview on 10/22/24 at 11:51 A.M. with the Director of Nursing (DON) confirmed on 09/23/24 STNA #28 took Resident #20 to the shower room, transferred the resident to the commode and then left the shower room. The DON confirmed Resident #20 had an unwitnessed fall without injury while trying to self-transfer off the commode. The DON confirmed Resident #20, and all residents should not be left alone in the shower room. Review of the facility policy titled Managing Falls and Fall Risk dated March 2018 revealed the staff would identify interventions related to the resident's specific risks to try to prevent the resident from falling.

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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** 32654 Based on medical record review, observation, staff interview and manufacturer's instructions, the facility failed to ensure staff primed insulin needles prior to insulin administration. This affected one (Resident #9) of five residents observed for medication administration. The facility census was 49 residents. Findings Include: Review of the medical record for Resident #9 revealed an admitted [DATE] with the diagnoses including chronic obstructive pulmonary disease, diabetes mellitus (DM), and Parkinson's disease. Review of the Minimum Data Set (MDS) assessment for Resident #9 dated 09/07/24 revealed the resident had no cognitive deficit, had DM as a current diagnoses and received daily insulin injections. Review of the physician's orders for Resident #9 revealed an order dated 03/12/24 for the resident to receive Lantus insulin 20 units daily for DM via subcutaneous injection. Observation on 10/22/24 at 8:20 A.M. of insulin administration for Resident #9 per Registered Nurse (RN) #1 revealed the nurse dialed the pen to 20 units, cleansed the resident's abdomen, and injected the insulin. The nurse did not prime the insulin pen prior to administration. Interview on 10/22/24 at 8:25 A.M. with RN #1 confirmed she did not prime the insulin pen prior to insulin administration for Resident #9 and she should have done so according to the manufacturer's instructions. Review of the Lantus pen instructions for use last revised October 2021 revealed the nurse should remove the seal from the safety pen needle, attach the safety pen needle securely to the pen injector device by twisting clockwise until it stops, and then prime the pen injector device prior to administration.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on observation, medical record review, staff interview and review of the facility policy, the facility failed to properly clean and disinfect glucometers after use. This affected one (Resident #9) of 12 facility-identified diabetic residents (#1, #7, #8, #9, #17, #19, #22, #23, #25, #27, #38, #45) who resided on the front hallway. The facility also failed to ensure staff practice proper infection control practices to prevent the potential spread of infection during wound care. This affected one (Resident #23) of one resident observed for wound care. The facility census was 49 residents. Findings include: Review of the medical record for Resident #9 revealed an admitted [DATE] with the diagnoses including chronic obstructive pulmonary disease, diabetes mellitus (DM), and Parkinson's disease. Review of the Minimum Data Set (MDS) assessment for Resident #9 dated 09/07/24 revealed the resident had no cognitive deficit, had DM as a current diagnoses and received daily insulin injections. Review of the physician's orders for Resident #9 revealed an order dated 03/12/24 for the resident to receive Lantus insulin 20 units daily for DM via subcutaneous injection. Observation on 10/22/24 at 8:20 A.M. of insulin administration for Resident #9 per Registered Nurse (RN) #1 revealed the nurse checked the resident's blood sugar using a glucometer prior to insulin administration. RN #1 cleansed the resident's finger with an alcohol wipe and pierced the resident's finger with a lancet and obtained a drop of blood. RN #1 [NAME] cleansed the multi-use glucometer with an alcohol swab and placed the glucometer on the resident's dresser. RN #1 then exited the room to obtained the resident's insulin, returned to the room and injected the insulin, and then left the room and placed the glucometer inside the medication cart. Interview on 10/22/24 at 8:25 A.M. with RN #1 confirmed she cleaned the glucometer following obtaining Resident #9's blood sugar with an alcohol swab instead of using an approved disinfectant wipe. Review of the facility policy titled Glucometer Cleaning undated revealed after using the glucometer staff should clean and disinfect using a germicidal disinfectant wipe. 2. Review of the medical record for Resident #23 revealed an admitted [DATE] with diagnoses cerebrovascular accident with left sided hemiplegia, diabetes mellitus, severe morbid obesity, and peripheral vascular disease. Review of the Minimum Data Set (MDS) assessment for Resident #23 dated 09/24/24 revealed the resident had a severe cognitive deficit and required extensive assistance of two staff for bed mobility, transfers and toilet use. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the physician's orders for Resident #23 revealed an order dated 09/12/24 to cleanse wound to the left calf wound with normal saline (NS), apply calcium alginate the wound bed and wrap with Kerlix every shift and an order dated 10/04/24 to cleanse the left heel with normal saline, apply a crushed 500 milligram (mg) Flagyl tablet to the wound bed, apply calcium alginate to the wound bed, and wrap with Kerlix every shift. Observation of wound care on 10/23/24 at 11:18 A.M. for Resident #23 per RN #2 and the Director of Nursing (DON) revealed the nurses washed their hands and donned gloves. The DON held the resident's left leg while RN #2 removed the soiled dressings from the resident's leg exposing a left calf wound and a left heel wound. RN #2 attempted to pulled the calcium alginate off the left calf wound, but the calcium alginate was adhered to the wound and RN #2 doffed gloves, washed her hands and exited the room. RN #2 returned to Resident 23's room, washed hands and donned clean gloves. RN #2 used a syringe of NS to soak the calcium alginate to the resident's left calf and removed it. The DON instructed RN #2 to wash her hands. RN #2 removed her gloves, washed her hands, and donned clean gloves. RN #2 then used the same NS-soaked gauze which she had used on the left calf wound and cleansed the resident's left heel. RN #2 then washed her hands, donned clean gloves, applied crushed Flagyl and calcium alginate to the resident's left heel. RN #2 then washed her hands and donned a clean pair of gloves. The DON then washed her hands and donned a clean pair of while RN #2 wearing the same gloves opened three pieces of 2 X 2 calcium alginate and placed them on an ABD pad and placed over the left calf wound. RN #2 then wrapped the resident's left heel with Kerlix gauze and then used another roll of Kerlix to wrap the left calf. Interview on 10/23/24 at 11:47 A.M. with the DON confirmed RN #2 had not practiced proper control practices to prevent the spread of infection because she treated the two separate wounds as one wound and used contaminated gauze to cleans the resident's left heel. The DON further confirmed each wound should be treated separately to prevent cross-contamination.