

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366016	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/31/2025
NAME OF PROVIDER OR SUPPLIER Main Street Terrace Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1318 E Main Street Lancaster, OH 43130	
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, interview, and review of service report and email, the facility failed to maintain a clean stove hood in the kitchen. This had the potential to affect all 45 residents residing in the facility. The facility census was 45. Findings include: Observation of the kitchen on 12/30/25 at 10:20 A.M. revealed the kitchen hood above the stove to be dusty. Observation of the inspection and cleaning sticker on the kitchen hood revealed it was last cleaned 08/27/25 and due again after 90 days. Interview with the Dietary Manager on 12/30/25 at 10:22 A.M. confirmed the kitchen hood above the stove was dusty and should have been cleaned and confirmed the kitchen hood was supposed to be cleaned every 90 days. The Dietary Manager further confirmed having paperwork to show inspections were completed but reported they were not the most current reports. Review of the service report revealed a date of 02/13/25. Review of an email dated 02/28/25 from Silco Fire and Security revealed the next inspection was scheduled for 03/06/25. There were no further service reports or documentation able to be provided.		

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on closed record review, interview, and review of the facility's Beneficiary Notices, the facility failed to provide notification to residents and/or representative within 48 hours. This affected one resident, (#53), of three residents reviewed for Beneficiary Notification. The facility census was 45. Findings include: Review of the closed record for Resident #53 revealed an admission date of 08/23/25 and discharge date of 09/13/25. Diagnoses for Resident #53 included, but were not limited to, dementia (9/9/25), obstructive and reflux uropathy (8/26/25), GERD (8/23/25), osteoarthritis (8/23/25), HTN (8/23/25), anxiety disorder (8/23/25), adult failure to thrive (8/23/25), anemia (8/23/25), altered mental status (8/23/25), pain (8/23/25), tachycardia (8/23/25), atherosclerotic heart disease (8/23/25), and obesity (8/23/25). BIMS for Resident #53, according to Minimum Data Set (MDS) section C, signed 09/15/25, was 11. Review of the facility's Beneficiary Notice revealed the notice for Resident #53 had an effective date of 09/11/25 for coverage to end. Further review revealed the telephone notice to Resident #53's representative was dated for 09/11/25 and signed by the Admissions Director 09/12/25. Interview with the admission Director 12/31/25 at 11:40 A.M. revealed Resident #53 no longer wished to reside at the facility as he wanted hospice through Veteran Affairs (VA), whom the facility did not contract with, and wanted to discharge as soon as possible. The admission Director reported the Notice of Medicare Non-Coverage (NOMNC) was issued as soon as possible, and confirmed the notification was signed on 09/12/25. The admission Director confirmed there was no documentation to confirm Resident #53's discharge was resident/family initiated and confirmed 48-hour notice was not given to Resident #53's representative.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review, interview, review of a facility Self-Reported Incident (SRI), review of December 2025 In-service Sign Off, and review of the facility's Resident Safety policy, the facility failed to complete resident abuse in-service reeducation for an agency aide involved in an abuse allegation following the investigation. This affected one, (#06), of three residents reviewed for abuse. The facility census was 45. Findings include: Review of Resident #06's record revealed an admission date of 11/11/25 with diagnoses of, but not limited to, muscle weakness (11/11/25), difficulty in walking (11/11/25), other lack of coordination (11/11/25), cognitive communication deficit (11/11/25), low back pain (11/11/25), chronic pain syndrome (11/11/25), weakness (11/7/25). Review of Resident #06's Minimum Data Set (MDS) signed 11/21/25 revealed a Brief Interview for Mental Status (BIMS) score of 14. Interview with Resident #06 on 12/29/25 at 1:50 P.M. revealed the resident had an incident with an aide, believed to have occurred a few weeks ago. Resident #06 reported the aide had been behind her and shoved her. Resident #06 reported having pain in her back following the incident to which she informed the aide, and the aide responded, you cry even when we touch your pinky finger. Resident #06 explained that she reported the incident to the facility Social Worker and was unsure of the outcome, but knew the aide was working at the facility still as the aide assisted another aide with changing her Depends this morning. Resident #06 reported she still felt safe at the facility. Interview with the Director of Nursing (DON) on 12/31/25 at 9:25 A.M. revealed the facility's response to unsubstantiated investigations of abuse/neglect is to re-educate staff on their Resident Safety policy. The DON reported that the aide involved in the incident with Resident #06 was an agency aide that picked up shifts as desired. The DON explained if an agency aide is involved in an incident and re-education is required the facility would have a one-on-one meeting with that staff person to complete the re-education. The DON reported being unable to provide documentation showing the re-education was completed with the agency aide involved in the incident with Resident #06, following the incident. Review of SRI ID #268464 created 12/10/25 confirmed an incident occurred with Resident #06 and a staff person where the resident reported being shoved by an aide. Review of the SRI revealed the facility completed an investigation and reported education would be provided to all staff providing care. The allegation was unsubstantiated. Review of the In-service Sign Off for topic Respiratory Assessment/Lung Sounds, Nebulizer Treatments, Trach Care/Oxygen Equipment Storage and Nebulizer and Tubing Equipment Checks/Abuse and Neglect, dated December 2025, revealed the agency aide listed on the SRI as the perpetrator had not been signed off as completing the re-education. Review of the facility's Resident Safety Policy, not dated, revealed all employees will have training at initial orientation and at ongoing sessions on issues related to resident safety.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure preadmission screening resident review (PASARR)'s were up dated with additional mental illness diagnoses. This affected three residents (#5, #8 and #23) of three residents reviewed for PASARR. The census was 45. Findings include: 1. Review of Resident #5's medical record revealed he was admitted to the facility on [DATE]. Diagnoses included dementia, diabetes, metabolic encephalopathy, emphysema, chronic respiratory failure, psychosis, depression, and anxiety disorder. Review of the quarterly MDS dated [DATE] revealed his cognition was not intact. He required set up or clean up assistance with eating, oral hygiene, dependent on toileting, personal hygiene, substantial/maximal assistance for shower/bathing and partial/maximal assistance with turning and repositioning. Always incontinent of bladder and always continent of bowel. Further review revealed a PASARR completed on 08/17/23. On 12/24/24 Resident #5 received a new diagnosis of anxiety disorder. There was no documented evidence a new PASAAR was completed after the new diagnosis. On 12/30/25 at 4:18 P.M. this was verified during interview with admission Director #201. 2. Review of Resident #8's medical record revealed she was admitted to the facility on [DATE]. Diagnoses included dementia, COPD, diabetes, mild protein calorie malnutrition, unspecified psychosis, PTSD, anxiety and major depression. Review of the quarterly minimum data set (MDS) assessment dated [DATE] revealed her cognition was intact (BIMS 15), she required set up or clean up assistance with meal set up, oral hygiene, substantial/maximal assistance for toileting, shower/bathing, personal hygiene and turning and repositioning. The resident was frequently incontinent of bowel and bladder. The resident's vision was impaired with no corrective lenses. Further review revealed a PASARR completed on 06/30/25 that did not include her anxiety disorder of Post Traumatic Stress Disorder (PTSD). On 12/30/25 at 4:18 P.M. this was verified during interview with admission Director #201. 3. Review of Resident #23's medical record revealed she was admitted to the facility on [DATE]. Diagnoses included COPD, severe protein calorie malnutrition, major depression, emphysema, peripheral vascular disease, PTSD and bipolar disorder. Review of the quarterly MDS assessment dated [DATE] revealed her cognition was intact, she was independent with eating, toileting, dressing, and personal hygiene, she requires set up or clean up assistance with oral hygiene, supervision or touching assistance with shower/bathing. Always continent of bowel and bladder. Has had a fall since admission. Further review revealed a PASARR completed on 08/22/25 which did not include her PTSD diagnosis. On 10/09/25 new diagnoses of anxiety disorder and major depression was added. There was no documented evidence to include the PTSD or the new diagnoses were added. On 12/30/25 at 4:18 P.M. this was verified during interview with admission Director #201.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on record review, review of care plan, and interview, the facility failed to ensure monitoring was in place for the side effects of opioid medications. This affected one (#4) of five residents reviewed for unnecessary medications. The facility census was 45. Findings include: Record review revealed Resident #4 was admitted to the facility on [DATE] with diagnoses including cerebral infarction, fracture of right fibula and fracture of shaft of left femur. Review of a care plan dated 06/18/25 revealed no evidence of monitoring for side effects of taking opioid medications. Review of an order dated 10/30/25 revealed Resident #4 had hydrocodone-acetaminophen oral tablet 5-325 milligrams (mg) one tablet by mouth every four hours as needed for pain. There was no evidence of an order for monitoring side effects for opioid medications. Review of a minimum data set (MDS) assessment dated [DATE] revealed Resident #4's cognition remained intact, she had no behaviors, she had frequent pain of two, and she took an opioid medication. Interview on 12/31/25 at 1:41 P.M. with the Director of Nursing (DON) confirmed there was not a care plan or an order to monitor Resident #4 for side effects related to taking an opioid medication.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents were provided a care conference quarterly. This affected one resident (#7) of one resident reviewed for care conferences. The facility census was 45. Findings include:Record review revealed Resident #7 was admitted to the facility on [DATE] with diagnoses including Parkinson's disease, asthma, and depression. Review of the medical record revealed there had been no quarterly care conferences since 01/21/25. Review of minimum data set (MDS) assessment records revealed Resident #7 had MDS' completed on 03/26/25, 06/26/25, and 09/26/25. Review of a MDS dated [DATE] revealed Resident #7's cognition remained intact and she had no behaviors. Interview on 12/29/25 at 1:30 P.M. with Resident #7 revealed she could not recall having a care conference. Interview on 12/30/25 at 1:21 P.M. with Social Worker (SW) #201 revealed the Director of Nursing (DON) is who usually documents care conferences. SW #201 stated care conference should be completed quarterly, with significant change, or as needed. SW #201 stated residents and family are invited to participate. SW #201 stated the schedule for care conferences is based on the scheduling of MDS'. SW #201 confirmed she was unable to provide documentation of Resident #7 being invited to or staff having a care conference for Resident #7 near 03/26/25, 06/26/25, or 09/26/25.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, and staff interview, the facility failed to ensure resident nebulizer equipment was stored in a safe and sanitary manner and not laying directly on their bed surface or bedside table. This affected two residents (Resident #01 and #23) of the three residents reviewed for oxygen. The facility census was 45. Findings include:1. Review of the medical record for Resident #01 revealed an admission date of 11/22/22 with a re-entry date of 12/05/23. Diagnoses included chronic obstructive sleep apnea, pulmonary disease, respiratory disorder, and malignant neoplasm of the pancreas and left lower right lung lobe. Review of Resident #01's annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating an intact cognition for daily decision-making abilities. Review of Resident #01's current physician orders revealed an order for Albuterol Sulfate inhalation 2.5 milligram (mg) per every 3 milliliter (ml), 0.083%, inhale 3 ml orally via nebulizer at twice a day for chronic obstructive pulmonary disease. Review of Resident #01's care plan dated 02/20/23 revealed this resident receives oxygen therapy related to respiratory illness related to COPD and a history of malignant neoplasm to right lower lobe. Interventions include to check oxygen saturations as needed and per nursing judgement, administer medication as ordered, give 2 liters of supplemental oxygen continuous with humidifier when using concentrator. Observation completed on 12/29/25 at 9:30 A.M. and on 12/31/25 at 2:00 P.M. revealed Resident #01's nebulizer mask laying on his bed surface without being placed in a protective bag. Interview with the DON on 12/30/25 at 4:12 P.M. confirmed Resident #01's nebulizer mask was not in the proper bag and was laying on this resident's bed. Even though this resident is able to take this mask off himself and turn the machine off, the nurse should still be making sure everything is put away properly. 2. Review of Resident #23's medical record revealed she was admitted to the facility on [DATE]. Diagnoses included COPD, severe protein calorie malnutrition, major depression, emphysema, peripheral vascular disease, PTSD and bipolar disorder. Review of the quarterly MDS assessment dated [DATE] revealed her cognition was intact, she was independent with eating, toileting, dressing, and personal hygiene, she requires set up or clean up assistance with oral hygiene, supervision or touching assistance with shower/bathing. Always continent of bowel and bladder. Has had a fall since admission. On 12/29/25 at 4:00 P.M. observation revealed the resident's nebulizer mask lying on the bedside table uncovered. Observations on 12/30/25 at 9:59 A.M., 3:43 P.M. and 4:11 P.M. revealed the nebulizer mask was on the bedside stand uncovered. This was verified during interview with the Director of Nursing at the time of the observation.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and observation the facility failed to ensure residents' pulse was monitored prior to administration of medication as well as pain medication had parameters in place related to the numeric pain scale. This affected two residents (#12 and #4) of the five residents reviewed for unnecessary medication. The facility census was 45. Findings include: 1. Review of the medical record for Resident #12 revealed an admission date of 02/22/21. Diagnoses included anxiety disorder, acute respiratory failure, hypertension, and Alzheimer's disease. Review of Resident #12's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 03 out of 15 indicating a severely impaired cognition for daily decision-making abilities. Review of Resident #12's current physician orders revealed an order for Atenolol (beta blocker) oral tablet 50 milligrams (mg) give one tablet in the morning. Hold for pulse less than 55. Review of Resident #12's medication administration record from 06/25 through 12/25 revealed on 06/03/25, 06/06/25, 07/12/25, 07/31/25, and 08/11/25 the Atenolol medication was documented as held due to outside of vital sign parameter, but the actual pulse reading was not documented. Also, this medication was noted to have been administered on 08/15/25, 08/17/25, and 08/20/25 with pulse readings below 55. Interview on 12/30/25 at 4:50 P.M. with the Director of Nursing (DON) confirmed there was multiple days where Resident #12's Atenolol medication was held due to the pulse (heart rate) being too low and the results were not documented. The DON also verified there were a few days that were marked with a VS indicating the pulse reading was below or above the ordered parameter and there were a few days noted where this resident was documented as receiving this medication when the resident's pulse was below 55. 2. Record review revealed Resident #4 was admitted to the facility on [DATE] with diagnoses including cerebral infarction, fracture of right fibula and fracture of shaft of left femur. Review of an order dated 06/18/24 revealed Resident #4 had acetaminophen tablet 325 milligrams (mg) give two tablets by mouth every eight hours as needed for general discomfort, not to exceed 3,000 mg in 24 hours. Review of an order dated 10/30/25 revealed Resident #4 had hydrocodone-acetaminophen oral tablet 5-325 mg one tablet by mouth every four hours as needed for pain. There was no evidence of either as needed pain medications having parameters to determine which medication to give based on the level of pain Resident #4 was expressing. Review of a minimum data set (MDS) assessment dated [DATE] revealed Resident #4's cognition remained intact, she had no behaviors, she had frequent pain of two, and she took an opioid medication. Interview on 12/31/25 at 1:41 P.M. with the Director of Nursing (DON) confirmed there were not parameters on as needed pain medications to guide nurses in determining which medication to give based on Resident #4's level of pain.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, food taste testing, and interview, the facility failed to prepare pureed foods in a way to maintain nutritious value and palatability. This affected three residents (#30, #35, and #42) of three residents on pureed diets. The facility census was 45. Findings include: Observation of puree lunch preparation on 12/30/25 at 10:30 A.M. revealed Dietary [NAME] (DC) #266 to be preparing barbeque pork and mixed vegetables. While pureeing the mixed vegetables, DC #266 added about 3/4ths a cup of water and three unmeasured portions of thickener throughout the puree process. Post pureeing the mixed vegetables, this surveyor tasted them and noted the flavor to be bland with little to no flavor. The Dietary Manager tasted the mixed vegetables as well and confirmed them to have little to no flavor. Interview with the Dietary Manager on 12/30/25 at 10:35 A.M. confirmed DC #266 used water and unmeasured amounts of thickener to prepare the pureed mixed vegetables. Dietary Manager confirmed DC #266 should have used broth to maintain nutritious value and palatability of the pureed vegetables instead of using water.		

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure residents were provided assistive devices as ordered. This affected one resident (#7) of one resident reviewed for assistive devices. The facility census was 45. Findings include: Record review revealed Resident #7 was admitted to the facility on [DATE] with diagnoses including Parkinson's disease, asthma, and depression. Review of an order dated 10/04/21 revealed Resident #7 was to receive plastic tumblers with lids for all drinks. Review of a minimum data set (MDS) dated [DATE] revealed Resident #7's cognition remained intact, she had no behaviors, and she received a mechanically altered diet. Review of a care plan initiated on 06/26/19 and revised on 12/26/25 revealed Resident #7 was at risk for altered nutrition and hydration related to body mass index, mechanically altered diet, and prone to edema. The goals were to consume adequate nourishment to achieve optimal nutrition with no signs or symptoms of dehydrations, aspirations or significant weight changes. Interventions included but were not limited to administer supplements as ordered, honor food preferences, offer 240 milliliters of water three times daily, and use only plastic tumblers with lids and no straws. Observation and interview on 12/30/25 at 3:55 P.M. with Certified Nursing Assistant (CNA) #260 confirmed Resident #7 had a plastic cup/tumbler with no lid in her room. Observation on 12/31/25 at 10:32 A.M. revealed Resident #7 was seated in her wheelchair with her head resting on the over the bed table, sleeping. There were two plastic cups on her table with no lids noted. Observation on 12/31/25 at 12:26 P.M. revealed Resident #7 was sitting in her wheelchair eating lunch in her room. She had six plastic cups on her tray with no lids. A policy for assistive devices was requested, but the facility did not have one.		