STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185242	A. Building B. Wing	11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Care Center	125 Sterling Way Mount Sterling, KY 40353

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 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. (continued on next page)

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview, record review, and review of the facility's investigation, the facility failed to immediately notify the resident's representative (s) when there was an identified injury, an accident, or a significant change in the resident's physical status, for 1 of 1 sampled resident, Resident (R) 2. The findings include:Review of R2's admission Record revealed the facility admitted the resident on 02/28/2022 with diagnoses to include chronic lymphocytic leukemia (CLL) and chronic kidney disease. A diagnosis of contracture left hand was added on 11/26/2023.Review of R2's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 08/19/2025, revealed the facility assessed the resident as having a Brief Interview for Mental Status [BIMS] score of six out of 15, indicating severe cognitive impairment. R2 was further assessed as dependent on staff for most Activities of Daily Living (ADL), as well as dependent on staff for ambulation. Review of the facility's investigation into R2's bruising revealed a statement, dated 09/19/2025, from the Sterling Unit Manager Registered Nurse (RN) 3, who reported she observed R2's bruising on 09/05/2025. The statement revealed the RN determined the bruise on R2's chest was located between and slightly above her breasts in the mid-upper sternal region and was about the size of an orange, with a dark purple center and some yellowing beginning on the upper portion of the bruise. The RN noted R2 had her hands clutched together in a fist against this area, which was consistent with the location of the bruising. Further review revealed a statement from the former Director of Nursing (DON), dated 09/19/2025, which stated she had been notified by the Sterling Unit nurse on 09/05/2025 that R2 had a bruise to her chest. The DON stated her assessment of R2's determined location and size of bruising was consistent with where R2 frequently clasped her hands tightly against her chest, and with R2's diagnosis of CLL and higher platelet count in her most recent blood work, R2 would bruise more easily. Further review of the DON's statement revealed the DON stated that based on her investigation, she was convinced bruising occurred due to R2 clasping her hands against her chest. She also stated her findings were discussed in the stand down meeting on 09/05/2025. The DON's statement concluded by noting she became ill and had to leave work early and had been unable to follow-up with the nurse that reported the bruising to her. Review of the facility's document Weekly Skin Observation, dated 09/08/2025, described the bruising to R2's chest as old bruising across the upper chest, appearing to have been there for several days based on the greenish, yellowish, purplish color of bruising. It stated the bruising was not a new skin injury. Review of the facility's Initial Report, dated 09/16/2025, revealed on 09/09/2025 bruising was observed to the center of R2's chest and reported to the family. Per the report, R2 denied anyone causing the bruise and was unaware of how it occurred. The report stated the bruise was reported as not suspicious or of unknown origin, with the report being initiated due to Adult Protective Services (APS) visiting the facility on 09/16/2025 to investigate the injury to R2. In an interview with R2's Family Member (F) 2 on 10/21/2025 at 11:25 AM, he stated bruising to R2 was in the process of healing prior to the family being made aware of it. He stated he felt like someone had dropped the ball somewhere in not reporting that to him, but he did not suspect R2 had been mistreated. In an interview with the Administrator on 10/22/2025 at 9:32 AM, he stated bruising to R2 was discussed initially in their 3:00 PM stand-down meeting on Friday 09/05/2025 when a nurse brought it to the DON's attention. He stated the DON investigated the bruising, but prior to a report being initiated, the DON fell ill. He stated on 09/11/2025, R2's daughter came in asking about the bruising and why they had not been informed of the bruising until 09/09/2025. The Administrator stated he had a conference call with R2's two daughters and son, and he informed them what the facility thought had caused the bruising. The Administrator stated the family told him they did not think anything abusive happened but were upset they did not get contacted on Friday when the bruising was discovered.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, review of the facility's investigation, and review of the facility's policies, the facility failed to ensure its staff practiced safe transfer techniques, utilizing a mechanical lift, to prevent injuries for 1 of 5 sampled residents, Resident (R) 1.On 04/02/2025, R1 was transferred from the bed to a chair by two State Registered Nurse Aides (SRNA) using a mechanical lift. SRNA4 was operating the lift, while SRNA1 was holding onto the lift pad during maneuvering. SRNA4 moved the lift from the bed to the chair, positioned the lift device under the chair, and failed to extend the legs, necessary for balancing the device. SRNA1 pulled on the lift pad to position R1 into the chair resulting in unbalanced weight distribution that caused the lift to tilt. The bar attachment struck R1 on the back of her head causing a laceration. R1 was transferred by ambulance to a local emergency room on [DATE] and required staples to close the wound.Based on review of the facility's plan of correction (PoC) and validation through observation, interview, and record review, the facility provided mandatory education and training regarding safe use of the mechanical lift. The State Survey Agency (SSA) validated the deficient practice was corrected on 04/16/2025, following completion of the mandatory employee education and training and before the start of the survey. Therefore, the deficient practice was past noncompliance.The findings include:Review of the facility's policy titled, Safe Resident Handling/Transfers, not dated, revealed the policy of the facility was to ensure residents were handled and transferred safely to prevent or minimize the risk of injury and provide and promote a safe, secure, and comfortable experience, while keeping employees safe in accordance with current standards and guidelines. Per the policy, two facility staff members would participate in the transfer process and be provided staff education and/or training and would be observed demonstrating competence at the time of hire, annually, and as needed. Review of the facility's policy titled, Accidents and Supervision, dated 11/01/2018, revealed the environment would remain as free of accident hazards as possible, and each resident would receive adequate supervision and assistive devices to prevent accidents. Review of R1's admission Record revealed the facility admitted R1 on 11/28/2018 with diagnoses of hemiplegia and hemiparesis following a stroke, dementia, dysphagia, and aphasia. Further review revealed R1 was discharged from the facility on 06/28/2025 due to death. Review of R1's annual Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 03/11/2025, revealed the facility assessed the resident's Brief Interview for Mental Status [BIMS] score could not be completed due to R1 being severely cognitively impaired. Review of Functional Abilities revealed R1 had limitations in range-of-motion in both lower extremities and was dependent in all self-care and mobility areas. Review of R1's Order Entry revealed a physician's order for a mechanical lift for transfers entered on 08/09/2022. Review of R1's Care Plan Report revealed a focus of having an Activities of Daily Living (ADL) self-care performance deficit related to diagnoses. Interventions included dependent with mechanical lift with two staff for transfers and required extensive staff assist of two for transferring.Review of R1's Health Status Note, dated 04/02/2025 at 8:36 AM, revealed two aides were transferring the resident using a Hoyer lift (mechanical lift) when it began to tip over. Per the note, while trying to keep it from falling, the lift bar hit R1 on the back of the head. The note stated the incident resulted in a laceration to the back of R1's head that required manual pressure be applied to control bleeding. Per the note, 911 was called, and the resident was transported to the hospital by ambulance and notifications were made. Review of R1's Health Status Note, dated 04/02/2025 at 12:53 PM, revealed the resident returned to the facility from the emergency room (ER) via ambulance with one staple in place to the laceration on the head with instructions for care and precautions. Review of R1's ER After Visit Summary, dated 04/02/2025 revealed a visit to the local ER for evaluation of fall resulted in an computed tomography (CT) scan of the brain and neck related to head trauma, a scalp laceration that was repaired with staple closure, and a diagnosis of a scalp hematoma, which was a collection of blood outside of the blood vessels under the skin, caused by trauma. Per the summary, R1 received an oral medication for pain and was administered a tetanus shot prior to discharge back to the facility with follow-up instructions.Review of R1's Incident Report, completed by Licensed Practical Nurse (LPN) 2, revealed LPN2 was standing outside of R1's door when a State Registered Nurse Aide (SRNA) was heard calling for help. LPN2 visualized R1 in the Hoyer lift sling in a chair with blood coming from the back of the head. LPN2 assessed R1 for further injuries, only noted the laceration to the back of the head, and pressure was applied to control bleeding. The report stated the assessment revealed R1 remained oriented to baseline, neurological check was normal, and a raised area of bleeding, known as a