STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375400	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Hills Nursing Center	2416 North Ann Arbor Oklahoma City, OK 73127

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, record review, and interview, the facility failed to ensure a resident was not touched sexually by another resident for 1 (#3) of 3 sampled residents reviewed for abuse. The facility's failure to prevent this type of inappropriate, unwanted sexual contact would reasonably cause anyone to have psychosocial harm.The administrator identified 54 residents resided in the facility. On 09/08/25 at 10:43 a.m., Resident #3 was observed lying in bed, with the bed in the low position, with fall mat in place. Their room was clutter free and the trash can was empty. Resident #3's room was next to the nurse's station on hall 300. Resident #3 was unable to appropriately respond to surveyor.On 09/09/25 at 1:08 p.m., Resident #27 was in attendance during resident council.On 09/09/25 at 2:00 p.m., Resident #27 was observed playing bingo in the dining room.On 09/10/25 at 10:25 a.m., LPN #2 and CNA #3 were observed coming out of Resident #3's room. Resident #3 was observed in bed repeating well, well, well, okay, okay, okay. The fall mat was observed in place next to bed. The bed was in low position, and the call light was in their hand.An Oklahoma State Department of Health final report, for an incident dated 09/02/25, showed LPN #2 went to Resident #3's room and found Resident #27 with their hand underneath Resident #3's gown near their groin with a fondling motion. Resident #27 asked Resident #3 if they liked it. LPN#2 asked Resident #27 what they were doing and Resident #27 stated they were trying to help Resident #3 into bed. Resident #3 was unaware of their circumstances or surroundings currently. Resident #27 was instructed not to go into other residents' rooms and Resident #27 stated they did not know what LPN #2 was talking about and then left the room. Resident #27 was immediately placed on 1:1 monitoring. Resident #3 had a head-to-toe assessment completed with no abnormalities noted. The physician, administrator, DON, local police and APS were notified. Resident #27 remained on 1:1 observation for 72 hours with no attempts to go into any other resident's room or exhibit any behaviors. The facility sent medical paperwork into numerous behavioral hospitals, and the resident had been accepted for in-patient evaluation once a bed became open. Resident #27's care plan would be updated for any new medication changes upon return from the hospital. If any future incidents occurred after return, the facility would look at alternative placement.A policy Abuse, Neglect and Exploitation, revised 01/18/25, read in part, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Sexual Abuse is non-consensual sexual contact of any type with a resident.Resident #3's Significant Change assessment, dated 07/03/25, showed Resident #3 had a BIMS score of 2 indicating severe problems with thinking and memory. The assessment showed Resident #3 had a diagnosis of metabolic encephalopathy [a brain dysfunction with symptoms that include confusion, memory loss, and altered consciousness]. The assessment showed Resident #3 was dependent upon staff for personal hygiene, dressing, bathing, transfers, toileting, and mobilization.A Nurse Progress Note, dated 09/02/25 at 1:59 p.m., showed Resident #3 was lying in their bed with the door open, and Resident #27 was found fondling underneath Resident #3's gown and asking if they liked it. Resident #3 was unable to respond appropriately to actions or questions from Resident #27. LPN #2 interrupted (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident #27's actions and asked what they were doing. Resident #27 stated they were trying to help Resident #3 get into bed. Resident #27 was instructed not to enter anyone's room without permission or staff presence.A Nurse Progress Note, dated 09/02/25 at 2:42 p.m., showed the evening shift nurse performed a head-to-toe assessment with no physical injuries or bruises noted. Resident #3 refused any pain medication but was anxious. Anxiety medication was last administered at 2:00 p.m.A Quarterly assessment for Resident #27, dated 08/09/25, showed a BIMS score of 6 which indicated severe problems with thinking and memory. The assessment showed Resident #27 had a diagnosis of dementia. The assessment showed Resident #27 required cues from staff for dressing, partial assistance with bathing, and substantial assistance with toileting.On 09/08/25 at 1:30 p.m., Resident #3's emergency contact #1 stated they lived in a different state and did not see Resident #3 often. They stated they were not aware of any abuse, but the facility did inform them of hospitalizations, Resident #3's refusal to eat and their rapid decline a few weeks ago. They stated Resident #3 gets taken care of as far as they know.On 09/09/25 at 9:30 a.m., LPN #2 stated the housekeeper noticed Resident #27 in Resident #3's room and alerted CNA #3, who then proceeded to alert them. LPN #1 stated they heard Resident #27 saying you like that, while they were touching Resident #3 under their gown around the groin area. LPN #2 stated Resident #27 had gotten more confused within the last two weeks. LPN #2 stated they asked Resident #27 about it the next day, but Resident #27 did not remember. LPN #2 stated they had never witnessed Resident #27 ever trying to enter Resident #3's room before. LPN #2 stated Resident #27 had entered another resident's room to go to the bathroom before. LPN #2 stated Resident #27 was easy to redirect.On 09/09/25 at 11:48 a.m., CNA #3 stated when they walked past Resident #3's room, Resident #27 was lifting the cover off of Resident #3, so they went to get the nurse. CNA #3 stated they had not seen Resident #27 do anything like that before.On 09/09/25 at 11:52 a.m., the administrator stated Resident #27 was put on 1:1 observation for 72 hours. The administrator stated Resident #27 did not go into any other resident's rooms or have any behaviors during that time. The administrator stated Resident #27 did not even remember the incident happened. The administrator stated they sent out referrals to three different behavioral health facilities to get Resident #27 evaluated. The administrator stated ultimately by the time a bed was available Resident #27 no longer qualified due to having no behaviors within the last 72 hours. The administrator stated their psychiatric doctor came to the facility once a month, but the facility was trying to get psychiatric to come weekly. The administrator stated Resident #3 and Resident #27 were their own responsible parties. The administrator stated there had been no other concerns since the incident. They stated they did not do Safe Surveys or any additional in-service training because the incident had been witnessed and stopped by staff. The administrator stated the facility had dementia training with a speaker in March of 2025. The administrator stated Resident #3 had not shown any signs of distress or acted any differently than previous to the incident.On 09/09/25 at 2:03 p.m., MDS coordinator #1 stated interventions were discussed in the morning stand up meeting. They stated Resident #27 was in the dining room with other residents 90% of the time. MDS Coordinator #1 stated the staff were made aware of the interventions through digital communication, and face to face shift report. They stated after the initial 72 hours of 1:1 observation, the staff were monitoring Resident #27's whereabouts.On 09/09/25 at 2:11 p.m., CMA #1 stated they were aware of the inappropriate touching, and that staff were instructed to keep an eye on Resident #27. CMA #1 stated Resident #27 was confused but was usually seen in the dining room playing games with other residents they lived with prior to being in the facility. CMA #1 stated they had never heard of Resident #27 doing anything like that before.On 09/09/25 at 2:13 p.m., LPN #3 stated they were aware of the incident and Resident #27 had been put on 1:1 monitoring but was unsure if that was still in effect. LPN #3 stated their responsibility when made aware of allegations of abuse was to make sure all the residents were safe, separate the residents, and try to educate the residents were able to comprehend. LPN #3 stated Resident #27 had never done anything like that before, and Resident #27 was usually in the dining room with their spouse, that is also a resident.On 09/09/25 at 2:17 p.m., (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	CNA #1 stated they had provided 1:1 observation on a morning shift after the incident. CNA #1 stated Resident #27 stayed in the dining room most of the day, ate popcorn, and went out to the patio. CNA #1 stated they did not see any inappropriate behavior, and they were not aware of any other incidents involving Resident #27.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on record review and interview, the facility failed to have a designated and trained infection preventionist to oversee the infection control program. The administrator identified 55 residents resided in the facility. Findings: The facility policy title Infection Preventionist, last reviewed 01/18/25, read in part, The facility will employ one or more qualified individuals with responsibility for implementing the facility's infection prevention control program.An undated Windsor Hills Nursing Center key staff list, provided by at the time of entrance conference, did not identify any staff members as an infection preventionist. On 09/08/25 at 10:25 a.m., during the entrance conference the DON and business office manager were asked to identify who the facility infection preventionist was. The DON stated they had been without an infection preventionist since the previous DON resigned. The DON stated they oversee the wounds in the facility and was not trained and certified to be an infection preventionist. On 09/09/25 at 10:12 a.m., the administrator was asked who the designated infection preventionist was and when they had left. The administrator stated the previous DON was the infection preventionist and they left on 08/15/25.

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. Based on record review and interview, the facility failed to ensure residents accounts within $200 of the $2,000 resource received notices of the balances for 4 (#3, 12, 34, and #23) of 5 sampled residents reviewed for balances in the and trust accounts. This had the potential for Residents (#3, 12, 34, and #23 to lose their Medicaid eligibility. The facility identified 23 residents with Medicaid as a payor source and had the facility manage their funds. Findings: An undated facility policy Resident Personal Funds, read in part, Notices of Certain Balances. The facility must notify each resident that receives Benefits: when the amount in the resident's account reaches $200 less than the SSI resource limit for one person.and if the amount in the account in addition to the value of the resident's nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid and SSI. 1. An undated face sheet for Resident #3 showed they had a payor source of Medicaid. A trust account ledger balance for Resident #3, dated 09/09/25, showed they had a current balance of $4666.92. 2. An undated face sheet for Resident #12 showed they had a payor source of Medicaid. A trust account ledger balance for Resident #12, dated 09/09/25, showed they had a current balance of $2479.44. 3. An undated face sheet for Resident #34 showed they had a payor source of Medicaid. A trust account ledger balance for Resident #34, dated 09/09/25, showed they had a current balance of $4699.50. 4. An undated face sheet for Resident #23 showed they had a payor source of Medicaid. A trust account ledger balance for Resident #23, dated 09/09/25, showed they had a current balance of $2,620.23 On 09/11/25 at 8:57 a.m., the business office manager stated the resource limit for residents on the trust account with a Medicaid payor source was $2,000. They stated the new system will generate a letter when the residents were within $200 of the resource limit but the old system did not have that. The business office manager stated they did not have documentation that showed notices had been provided but would look and see if they could find anything. No further documentation was provided to show the notices had been provided.

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	375400	A. Building B. Wing	09/11/2025

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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. Based on observation, record review, and interview the facility failed to develop a care plan for the provision range of motion services for 1 (#6) of 1 sampled resident reviewed for range of motion.The administrator identified eight residents with range of motion deficits. Findings: On 09/08/25 at 12:45 p.m., Resident #6 was observed in their room with his right hand slightly contracted and unable to move his right side. An undated facility policy titled Prevention of Decline in Range of Motion, read in part, Appropriate care planning . Based on the Comprehensive assessment, the facility will provide interventions, exercise and/or therapy to maintain or improve range of motion. An undated admission Record for Resident #6 showed they had diagnosis of hemiplegia and hemiparesis following a cerebral infarction affecting the right dominant side. An annual assessment for Resident #6, dated 06/19/25, showed they were severely cognitively impaired with a BIMS score of five. The assessment showed Resident #6 had upper and lower range of motion deficits. A care plan for Resident #6, last reviewed 06/02/25, read in part, I have a problem expressing myself to others because I had a stroke and it affecting my speech. The care plan was not developed to address Resident #6's ROM deficit to their right side. On 09/10/25 at 1:23 p.m., CNA #2 stated Resident #6 had stiffness to their right arm and had the limited use to the right side since they had been working here for two years. On 09/09/25 at 1:30 p.m., CNA #1 stated they had worked here for six months, and Resident #6 was weak on the right side due to a stroke. On 09/10/25 at 1:49 p.m., MDS coordinator #1, stated Resident #6 had right sided weakness and range of motion deficits. They stated the care plan did not address the range of motion and right-side weakness and it should have been developed and addressed.

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	375400	A. Building B. Wing	09/11/2025

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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. Based on observation, record review, and interview, the facility failed to implement infection control practices a. for the care of oxygen tubing for 2 (#9 and #36) of 2 sampled residents reviewed for respiratory care, and b. for utilizing EBP during the provision of wound care for 2 (#8 and #12) of 2 sampled residents reviewed for wound care.The administrator identified 14 residents who had orders for oxygen and 18 residents that required the use of EBP. Findings: An undated facility policy Enhanced Barrier Precautions, read in part, It is the policy of this facility to implement enhanced barrier precautions of transmission of multi-drug-resistant organisms.An order for enhanced barrier precautions will be obtained for residents with any of the following: wounds. 1. On 09/08/25 at 2:28 p.m., Resident #12's room was observed. A sign located on the door showed Resident #12 was on EBP. On 09/10/25 at 10:02 a.m., LPN #1 was observed performing Resident #12's wound treatment. LPN #1 gathered supplies, set up a barrier on the bedside table, washed their hands and donned a pair of gloves. LPN #1 did not put a gown on. LPN #1 applied a treatment and doffed her gloves. LPN #1 was observed without washing their hands and donning a new pair of gloves applying a sterile boarded gauze. LPN #1, after applying the gauze, went to the sink, washed their hands and donned a new pair of gloves. After applying the treatment to the second wound to Resident #12, LPN #1 took of their gloves and with their bare hands applied a band-aide dressing. LPN #1 did not wear a gown and did not perform proper handwashing and gloves changes. An undated face sheet for Resident #12 showed they had diagnoses which included the absence above the knee right and left leg, non-pressure chronic ulcer of buttock limited to break down of skin, stage III pressure ulcer. A physician order for Resident #12, dated 02/18/25, read in part, Enhanced Barrier Precautions (EBP) per CMS/OSDH guidelines. every shift for enhanced barrier precautions. A care plan for Resident #12, last revised 09/09/25, showed they had breakdown related to impaired mobility and disease process. The interventions read in part, Enhanced Barrier Precautions (EBP) per CMS/OSDH guidelines On 09/08/25 at 2:31 p.m., Resident #12 stated they had wounds that were being treated, and staff completed the treatments as ordered. Resident #12 stated staff did not always wear gloves and gowns when performing wound care. On 09/10/25 at 10:45 a.m., after the wound care was finished, LPN #1 was asked what the EBP sign on Resident #12's room meant. LPN #1 stated full PPE was not to be worn unless the resident had an infection. On 09/10/25 at 2:18 p.m., the DON stated EBPs were to be used when residents had wounds, a colostomy, or any port or open area on their body. The DON stated staff were to wear gloves and gowns when providing direct care. The DON stated they did not monitor to ensure the staff were utilizing EBP when providing care and wound treatments. 2. On 9/10/25 at 1:48 p.m., LPN #2 was observed providing wound care to Resident #8. LPN #2 (continued on next page)

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	375400	A. Building B. Wing	09/11/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	washed their hands and donned a pair of gloves. LPN #2 did not put a gown on. LPN #2 removed dressing and cleaned the wound. The wound to buttocks was actively bleeding after the light cleaning with gauze. LPN #2 doffed gloves and donned new gloves. LPN #2 did not sanitize their hands. LPN #2 applied a collagen treatment and a foam pad, secured with a border dressing, and doffed their gloves. LPN #2 donned a new pair of gloves. LPN #2 did not put a gown on. LPN #2 removed dressing and cleaned the wound to right heel. LPN #2 doffed gloves and donned new gloves. LPN #2 did not sanitize their hands. LPN #2 donned new gloves and then applied a treatment and doffed their gloves. After completing the dressing LPN #2 went to the sink and washed their hands. An undated face sheet for Resident #8's showed they had a diagnosis of stage III pressure ulcer to the right heel. A physician order for Resident #8's, dated 02/19/25, read in part, Enhanced Barrier Precautions (EBP) per CMS/OSDH guidelines. every shift for enhanced barrier precautions. A care plan for Resident #8, last revised 08/27/25, showed they had impairment to skin integrity related to a deep tissue injury on the right heel. The care plan showed Resident #8 had maceration and shearing to the left buttocks. On 09/08/25 at 10:58 a.m., Resident #8 stated they had wounds, but staff did not wear gowns when they provided wound care or ADL care. On 09/10/25 at 2:08 p.m., LPN #2 was asked what EBPs were. LPN #2 stated they did not know and then guessed it was when they lay the barrier on the bedside table to place the wound supplies on. LPN #2 was asked if there was an EBP sign on the door to alert staff they should be using EBP. LPN #2 stated no. 3. On 09/09/25, at 10:14 a.m., Resident #9 was observed to have a nasal canula on. The tubing was not labeled when it was last changed. An undated facility policy Oxygen Administration, read in part, Change oxygen tubing and mask/canula weekly and as needed. An undated face sheet for Resident #9, showed they had diagnoses which included anxiety, chronic obstructive pulmonary disease, epilepsy, and unspecified systolic congestive heart failure. A physician's order, dated 06/03/24, showed Resident #9 was to receive 2 liters of oxygen via nasal canula. A physician's order, dated 08/31/25, documented to change the oxygen tubing every Sunday on the 10:00 p.m. - 6:00 a.m. shift. On 09/09/25 at 10:16 a.m., Resident #9 stated the last time the tubing was changed was last week 4. On 09/09/25 at 11:05 a.m. Resident #36 was observed in bed with a nasal canula on. There was no date on the tubing. An undated face sheet for Resident #36 showed they had diagnoses which included anemia, chronic kidney disease, depression, and hypertension. (continued on next page)

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	375400	A. Building B. Wing	09/11/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's order, dated 08/31/25, showed Resident #36 was to receive 2 liters of oxygen via nasal canula. There was no order for changing the tubing. On 09/10/25 at 11:24 a.m., LPN #3 was asked about the procedure when changing oxygen tubing. LPN #3 stated they put their name, date, and time of the tubing change on the mask. LPN #3 was asked about the last time the tubing was changed for Resident #36. LPN #3 stated they did not know because the night shift nurse was supposed to complete the task. LPN #3 stated there was not an order for changing the oxygen tubing for Resident #36. On 09/10/25, at 11:37 a.m., the DON was asked about Resident #36's order for oxygen. The DON stated the order was not complete. The DON was asked about the policy regarding the tubing needing to be changed. The DON stated their policy was tubing needed to be changed weekly on Sundays with the initials, date, and time.

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	375400	A. Building B. Wing	09/11/2025

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, record review, and interview, the facility failed to ensure call lights were within reach for 2 (#10 and #19) of 23 sampled residents reviewed for call light accessibility.The administrator identified 55 residents resided in the facility.Findings:A Call Lights: Accessibility and Timely Response policy, copyright date 2024, read in part, Staff will ensure the call light is within reach of each resident and secured, as needed. 1. On 09/08/25 at 10:24 a.m., Resident #19s call light button was observed on the floor. An annual assessment, dated 08/05/25, showed Resident #19 had a BIMS of 15, indicating no cognitive impairment. The assessment showed Resident #19 was dependent on staff for dressing, toileting, bathing, transferring, and bed mobility. On 09/08/25 at 10:28 a.m., LPN #2 stated I don't know how the call light got in the floor (for Resident #19), it should not be, it is supposed to be in the resident's reach at all times. 2.On 09/08/25 at 10:48 a.m., Resident #10's call light was observed at the foot of the bed, out of reach of resident. A quarterly assessment, dated 09/04/25, showed Resident #10 had a BIMS of 11, indicating moderate impairment of cognition. The assessment showed Resident #10 required maximum assistance with dressing, toileting, bathing, and transferring. On 09/08/25 at 10:49 a.m., CMA #2 stated the call light was at the foot of the bed, where Resident #10 could not reach it

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	375400	A. Building B. Wing	09/11/2025

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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 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. Based on record review and interview the facility failed to ensure care plans were updated to reflect the current status of medications for 1 (#53) of 5 sampled residents reviewed for unnecessary medications. The administrator identified 35 residents received psychoactive medications. Findings: An undated admission record for Resident #53 showed they had diagnoses which included respiratory disorders in disease classified elsewhere, chronic pain, constipation, sleep apnea, ventricular fibrillation, atrial fibrillation, insomnia, anxiety, adjustment disorder with mixed anxiety, and depression. Resident #53's orders for Buspirone (an anti-anxiety medication) showed the medication was discontinued on 07/13/25. Resident #53's orders for trazadone (an antidepressant) showed the medication was discontinued on 07/13/25. A care plan for Resident #53, last updated 07/23/25, showed the resident was currently taking Trazadone and Buspirone. On 09/09/25 at 2:28 p.m., MDS coordinator #1, stated they were responsible for updating care plans for the residents. They stated Resident #53's Trazadone and Buspirone was discontinued on 07/13/25. MDS Coordinator #1 was asked if the care plan reflected the current status of medication use. They stated the medications were not taken off the care plan and they should have been.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375400	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Hills Nursing Center	2416 North Ann Arbor Oklahoma City, OK 73127

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, record review, and interview the facility failed to provide range of motion services for 1 (#6) of 1 sampled resident reviewed for range of motion services. The administrator identified eight residents with range of motion deficits. Findings: On 09/08/25 at 12:45 p.m., Resident #6 was observed in their room with his right hand slightly contracted and unable to move his right side. An undated facility policy titled Prevention of Decline in Range of Motion, read in part, Appropriate care planning . Based on the Comprehensive assessment, the facility will provide interventions, exercise and/or therapy to maintain or improve range of motion. An undated admission Record for Resident #6 showed they had diagnoses which included hemiplegia and hemiparesis following a cerebral infarction affecting the right dominant side. An annual assessment for Resident #6, dated 06/19/25, showed they were severely cognitively impaired with a BIMS score of five. The assessment showed Resident #6 had upper and lower range of motion deficits. A care plan for Resident #6, last reviewed 06/02/25, read in part, I have a problem expressing myself to others because I had a stroke and it affecting my speech. The care plan was not developed to address Resident #6's ROM deficit to their right side. On 09/10/25 at 1:23 p.m., CNA #2 stated Resident #6 had stiffness to their right arm and had the limited use to the right side since they had been working there for two years. On 09/09/25 at 1:30 p.m., CNA #1 stated they had worked there for six months, and Resident #6 was weak on the right side due to a stroke. On 09/10/25 at 1:35 p.m., LPN #1 stated Resident #6 had limited use to their right side due to a stroke. LPN #1 stated Resident #6's right hand was tight and they needed to make sure their nails were kept trim. LPN #1 stated they did not know of Resident #6 having restorative services. On 09/10/25 at 1:40 p.m., RA #1 stated they had been doing restorative services for six months and they had 19 residents on services. RA #1 stated Resident #6 was not receiving any services and they had ROM deficits due to a stroke. RA #1 stated MDS coordinator #1 was the one who assisted with determining residents that would benefit from the services. On 09/10/25 at 1:49 p.m., MDS Coordinator #1, stated Resident #6 had right sided weakness and range of motion deficits. They stated Resident #6 is not on a restorative program and no ROM services were being provided. MDS Coordinator #1 stated they were not sure when Resident #6 had been screened and would look for documentation to show when they were screened. No additional documentation was provided.