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

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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. 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 (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	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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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. **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 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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 hematoma, was evident on the head. Per the report, notifications were made to the physician, family, and Director of Nursing (DON), and R1 was transferred to the ER. Further review revealed the two SRNAs involved, SRNA1 and SRNA4, described the incident as: one SRNA was holding the handles of the Hoyer pad that held R1 and pulled on it causing the Hoyer lift device to tilt to one side, the other SRNA attempted to catch the lift to keep it from falling over, and the action caused the bar of the device to hit R1 on the back of the head. Further review of the document revealed there were no predisposing environmental factors. The report stated R1 had predisposing physiological factors of history of falls and weakness/fainted and a predisposing situation factor of transferring with staff assistance.Review of the handwritten Witness Statement, dated 04/02/2025 and signed by SRNA1, revealed SRNA1, along with SRNA4, was placing R1 in the chair using the lift. SRNA1 was holding onto the lift pad straps and pulling R1 into position into the chair, and the lift started to tip over. Per the statement, SRNA4 attempted to keep the lift from falling over causing the lift device to come down and hit R1 in the head. Review of the handwritten Witness Statement, dated 04/02/2025 and signed by SRNA4, revealed SRNA1 and SRNA4 were getting R1 up with the Hoyer lift when SRNA1 pulled the lift pad back to position the resident in the chair while SRNA4 had hold of the device handles. Per the statement, the device started to tip, and SRNA4 attempted to catch it. Further review revealed Licensed Practical Nurse (LPN) 2 was outside the room and entered to help get R1 detached from the device. The statement revealed R1 was bleeding from the head and pressure was applied to control bleeding.Review of the handwritten Statement, dated 04/02/2025 and signed by former Director of Nursing (DON) 1, revealed SRNA1 and SRNA4 were using the Hoyer lift for R1. Per the statement, SRNA1 reported holding the handles of the lift pad, and when it was pulled back, the lift started to tip over to the right. The statement revealed SRNA4 tried to keep the lift from falling over, and the bar of the lift came down and hit R1 in the back of the head causing a laceration and raised hematoma.Review of SRNA1's employee file revealed a Validation Checklist Mechanical Lift document dated 04/02/2025 with satisfactory completion for all listed procedures. Review of SRNA4's employee file revealed a Resignation/Termination Form, dated 04/02/2025, with the last day worked and termination of 04/02/2025, which was handwritten. The form stated the discharge was due to failure to use proper lifting techniques; non-compliance with safe body mechanics training, and unsafe work conduct, procedures, habits, practices, or methods. The form was signed and dated 04/02/2025 by Director of Nursing (DON) 1. Further review revealed an Employee Disciplinary Action form, dated 04/02/2025, with a handwritten note which stated, Failure to use Hoyer lift properly. Also, another handwritten text stated, Did not spread legs of Hoyer lift causing it to tip sideways and injured a resident. The form was signed by DON1, SRNA4, and the Administrator, all dated for (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	04/02/2025.In an interview with the Complainant on 10/21/2025 at 9:44 AM, she stated someone from the facility notified her on 04/02/2025 that while using the mechanical lift device, R1 had fallen and was being taken to the hospital. The Complainant stated when she arrived at the hospital, she was told the legs on the mechanical lift had not been extended, the lift fell, and R1 hit her head, which resulted in a laceration to the back of the head that required at least one staple. In an interview with SRNA1 on 10/21/2025 at 10:50 AM, she stated she had been one of two SRNAs that were present during the Hoyer lift accident involving R1 on 04/02/2025. SRNA1 stated she and SRNA4 were using a Hoyer lift to transfer R1 to a chair, and SRNA4 was the operator of the controls, steering the machine, and she was holding onto the pad and the resident. She stated once R1 was positioned over the chair, she pulled on the lift pad to make sure R1 was directly over the seat, and the machine started to tilt. She stated SRNA4 attempted to stabilize it with her hands, but a part of the bar at the top of the machine ended up striking R1 on the back of the head. SRNA1 stated she was yelling, and a nurse that was outside the door came in, provided assistance unhooking R1 and getting her in the chair, identified bleeding from the head, held pressure and called for an ambulance. She stated, after R1 had been taken to the emergency room, she was questioned by DON1 and wrote a statement of the incident. She stated, later that same day she had to complete education on safe transferring and use of the Hoyer lift. She stated she had to do a return demonstration as a competency validation.In an interview with SRNA4 on 10/21/2025 at 2:17 PM, she stated she was one of two SRNAs that was present during the Hoyer accident involving R1 on 04/02/2025. SRNA4 stated she was the operator of the machine, and SRNA1 was the second person, holding onto the sling pad holding R1. SRNA4 stated once R1 was positioned over the chair, SRNA1 pulled on the sling pad, and the machine started to tilt. She stated the attachment connecting the sling to the machine hit R1 in the head. She stated a nurse standing outside the door came in and helped stabilize the machine, helped get R1 into the chair, and held pressure on R1's head wound. SRNA4 stated, after R1 had been taken to the hospital, DON1 asked her to write a statement about the event. SRNA4 stated she explained to DON1 that R1 was being transferred from the bed to a Geri chair, and after moving the Hoyer to the chair, the legs of the machine could not be extended, so they were not extended at the time of the incident. SRNA4 stated later the same day as the incident, she was called into DON1's office and was fired. In an interview with Maintenance staff on 10/22/2025 at 10:00 AM, he stated all mechanical lift devices were checked on a monthly basis for preventative maintenance. He stated monthly inspection of the device included checking all moving parts and the battery. He stated that included ensuring the controllers worked, the machine moved up and down properly, the brakes were working, and the legs extended and retracted appropriately. He stated he had been informed of the accident with the Hoyer lift by the Administrator, and he did an inspection of the lift and could not find any problem with the mechanics of the machine. He stated he informed the Administrator of his findings. In an interview with DON1 on 10/22/2025 at 10:55 AM, she stated she had been notified of the incident by a staff nurse and did the investigation. DON1 stated after R1 had been taken to the hospital, she questioned the staff involved, had them demonstrate to her what they had done, and then had them write out statements. She stated after the demonstration and interviews, it was determined one of the two SRNAs had positioned the Hoyer device under the chair in a way that did not allow the legs to be extended, which was necessary for proper operation. However, she stated SRNA4 continued with the use of the device, and when SRNA 1 pulled on the lift pad to position the resident, the machine became unbalanced and tilted. She stated that resulted in a head injury to R1. She stated the incident was determined to be an isolated incident caused by an employee not following procedure.In an interview with the Administrator on 10/22/2025 at (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	9:40 AM, he stated he was notified by DON1 of an incident with a Hoyer lift that resulted in an injury to a resident. He stated DON1 questioned both SRNAs involved, had them demonstrate exactly what happened, and they wrote statements. The Administrator stated after the demonstration and interviews with both SRNAs, it was determined it had been an isolated incident due to not following safety and transferring policy and not using the Hoyer lift appropriately resulting in one of the two SRNAs being terminated the same day. He stated management staff met to discuss the situation and had maintenance inspect the lift. The facility provided an acceptable plan of correction (PoC) on 10/21/2025 alleging past non-compliance of the deficient practice and a date of compliance of 04/16/2025, with corrective actions and validation as follows:Review of the facility's folder Mechanical Lift Education revealed a document, Staff In-Service Attendance Record, with the subject Mech [Mechanical] Lift Safety Safe Resident Handling & Transfers, dated 04/02/2025, with the handwritten instructor's name and Staff Development. There were three sign-in sheets with a total of 78 signatures over the three pages. A printed handout, Patient Lifts Safety Guide, was 16 pages of pictures and wording that described the parts of a lift device, selecting sling size, preparing the environment, placing patient in the sling, lifting the patient, sling care, caregiver safety tips, and a blank copy of the validation checklist for mechanical lifts. Observation by the State Survey Agency (SSA) Surveyor on 10/21/2025 at 3:21 PM revealed SRNA1 and SRNA2 used a Hoyer lift device for transfer of R4 from a specialty chair to the bed. Staff donned appropriate personal protective equipment (PPE) prior to entering the room, the lift pad was under R4 in the chair, the device was placed appropriately beside the resident, wheels were locked, and the legs of the lift were extended, and the sling was connected to the device appropriately. SRNA1 operated the lift controls to raise R4 from the chair, while SRNA2 kept a hand on the sling and R4. SRNA1 unlocked the wheels and maneuvered the device over the bed while SRNA2 maintained both hands on R4 to steady and control movement. Once R4 was positioned over the bed in the proper location, SRNA1 locked the wheels and operated the lift controls to lower R4 while SRNA2 continued hands on guiding of R4 during lowering. Once staff had placed R4 safely back to bed, removal of the sling and final positioning was performed. In a continued interview with the Complainant on 10/21/2025 at 9:44 AM, the Complainant stated she had received communication from DON1 and the Administrator, after the incident, and had been informed that one of the two staff had been fired, and all staff had been trained on the correct way to use the lift device.In an interview with Registered Nurse (RN) 2/Staff Development Specialist (SDS) on 10/21/2025 at 1:38 PM, she stated she had been in the position of staff education for about two weeks when the incident occurred. RN2 stated the Manager for the unit and DON1 came to her and told her they needed immediate education concerning the use of Hoyer lifts, instructed her on what material to gather, and what needed to be done. RN2 stated she had an empty room set up with a Hoyer lift and a mannequin, and clinical staff were brought in small groups and given the packet of instructions along with the facility's policy on transferring. She stated all clinical staff on all shifts were required to sign-in on a roster, verbalize proper steps, and completed the return demonstration to be considered compliant, before they could work their next shift. She stated completion of the education was ongoing for about two weeks before all staff were compliant. RN2 stated all new hire clinical staff received the same Hoyer lift training during orientation and again annually during skills day.In the interviews with nine staff on 10/22/2025, they all stated they received verbal instruction with a demonstration and a return demonstration required for proper use of a mechanical lift to include two staff to operate, legs must be extended, use the appropriate sling size, and ensure the resident was secured. The staff members interviewed were RN3 at 11:20 AM, SRNA5 at 11:29 AM, SRNA7 at 11:40 AM, LPN4 at 1:51 PM, SRNA/Kentucky (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Medication Aide (KMA) 9 at 2:07 PM, LPN3 at 2:15 PM, LPN5 at 2:24 PM, SRNA11 at 2:40 PM, and SRNA15 at 2:51 PM.In a continued interview with DON1 on 10/22/2025 at 10:55 AM, she stated the facility decided to do mandatory education for all clinical personal that operated the Hoyer lift. DON1 stated a training packet of information on proper use was put together, and training was started the same day as the incident and was required by all clinical staff before the start of their next shift. She stated she believed the incident had been discussed at Quality Assurance Performance Improvement (QAPI) meetings, but she did not recall the specifics. Review of the QAPI meeting minutes, dated 04/10/2025, revealed there had been training for all clinical staff on mechanical lifts due to a resident injury sustained during its use. Further review revealed all lift devices had been checked for proper functioning after the resident injury. Review of the QAPI meeting minutes, dated 05/08/2025, revealed the in-service for the clinical staff on the use of mechanical lifts was 100 percent complete.In a continued interview with the Administrator on 10/22/2025 at 9:40 AM, he stated, after the incident with R1, management staff determined mandatory education for anyone using the lift would begin immediately and be required before working their next shift. The Administrator stated a Quality Assurance Performance Improvement (QAPI) committee meeting was held on 04/10/2025. He stated, at that meeting, the incident was discussed, findings were given, and mandatory education had been started the day of the incident. He stated discussion on need for an action plan was determined not to be required due to the committee members' agreement that the incident was isolated, the employee had been terminated, and all clinical staff were required to attend education of the lift. He stated at the following month's QAPI meeting, an update was given that 100% compliance of the mandatory education had been completed, and the committee agreed that no further actions would be necessary.