## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/20/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  - A. BUILDING		(X3) DATE SURVEY COMPLETED		
18524		185242	B. WING			05/12/2020	
NAME OF PROVIDER OR SUPPLIER WINDSOR CARE CENTER				125 STERL	DRESS, CITY, STATE, ZIP CO ING WAY TERLING, KY 40353	ODE	12/2020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			X (E/	PROVIDER'S PLAN OF COR ACH CORRECTIVE ACTION SS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 000	was initiated on 05/ 05/12/2020. The far compliance with 42 regulations and has Medicare & Medica Centers for Disease	sed Infection Control Survey 11/2020 and concluded on cility was found to be in CFR 483.80 infection control implemented the Centers for id Services (CMS) and c Control and Prevention ed practices to prepare for	FO	00			
APOPATORY	DIRECTORIS OF PROVIDE	ER/SUPPLIER REPRESENTATIVE'S SIGN			TITIF		

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.

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185242		B, WING	·	05	05/12/2020		
NAME OF PROVIDER OR SUPPLIER WINDSOR CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP 125 STERLING WAY MOUNT STERLING, KY 40353	CODE	Vi.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIED TO THE APP		(X5) COMPLETION DATE	
E 000	Survey was initiated concluded on 05/12	eed Emergency Preparedness d on 05/11/2020 and 1/2020. The facility was found with 42 CFR 483.73 related	ΕC	000			
	ď						
*		•					
LABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	JATURE	TITLE		(X6) DATE	

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.

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FORM APPROVED Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER. COMPLETED A. BUILDING: \_\_\_\_\_ B. WING 100468 05/12/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 125 STERLING WAY WINDSOR CARE CENTER **MOUNT STERLING, KY 40353** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE **PRÉFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) N 000 Initial Comments N 000 A COVID-19 Focused Infection Control Survey was initiated 05/11/2020 and concluded on 05/12/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE