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

PRINTED: 01/02/2021 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	
		185242	B. WING		12/22/2020	
NAME OF PROVIDER OR SUPPLIER WINDSOR CARE CENTER				STREET ADDRESS, CITY, STATE, ZI 125 STERLING WAY MOUNT STERLING, KY 4035	P CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		I SHOULD BE COMPLÉTION	
F 000	A COVID-19 Foc was initiated on 1 12/22/2020. The compliance with 4 regulations and haddicare & Medicare & Medic Centers for Disea	used Infection Control Survey 2/22/2020 and concluded on facility was found to be in 42 CFR 483.80 infection control as implemented the Centers for caid Services (CMS) and se Control and Prevention aded practices to prepare for		000		
6 %		*				
			7			
ABORATORY	DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185242	B. WING		12/22/2020
NAME OF PROVIDER OR SUPPLIER WINDSOR CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CO 125 STERLING WAY MOUNT STERLING, KY 40353	DE .
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOTT TAG CROSS-REFERENCED TO THE APPLICATION OF CORRECT PROVIDER'S PLAN OF CORRECT PROVIDER'S		HOULD BE COMPLÉTION
E 000	Survey was initiat concluded on 12/2	used Emergency Preparedness ed on 12/22/2020 and 22/2020. The facility was found be with 42 CFR 483.73 related	ΕO	000	
AROBATORY	DIRECTOR'S OR PROVI	IDER/SUPPLIER REPRESENTATIVE'S SIGN	MATURE	TITLE	(X6) DATE

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(X6) DATE

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: _ 100468 B. WING 12/22/2020 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 PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE **DEFICIENCY**) N 000 Initial Comments N 000 A COVID-19 Focused Infection Control Survey was initiated on 12/22/2020 and concluded on 12/22/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80 infection control regulations and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total census 104.

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

TITLE

(X6) DATE