STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105882	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winkler Court	3250 Winkler Avenue Extension Fort Myers, FL 33916

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to provide a safe, clean, comfortable and home-like environment for residents, staff and the public. The findings included: During an observation of the memory care unit on 4/21/25 from 8 a.m. to 12 p.m. the following was observed: Cracked walls with exposed plaster above air conditioning units, walls and corners including Rooms 208, 205, 204, 201, 206, 203, dining room and main hallway. Missing/broken closet doors including rooms [ROOM NUMBERS]. Foam sprayed in the bottom corner of the window near the back exit door. Chair/Bed rail missing off wall in room [ROOM NUMBER]. Broken window blinds including Rooma 204, 201, 207, 206, and 209. Peeling cove base in common hallway, dining room, and rooms [ROOM NUMBER]. The floors of the common hallway were cracked, stained and missing pieces. Tile was missing from the bathroom wall with exposed plaster in room [ROOM NUMBER]. Sink in Rom 208 was separated from the wall and wiggled when you touched it. On 4/21/25 at 3:15 p.m., the Memory Care dining room cabinets were noted to have ground in dirt in the corners between floor and cabinets, the cabinet under the sink contained a Styrofoam cup with a half-eaten chicken wing, scattered debris, used napkin, dried spilled brown substance and small black particles. A second cabinet was opened which contained an empty opened milk container, and a third cabinet which contained staining, a sandwich bag with some type of bread substance inside it, and assorted debris. (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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/21/25 at 3:25 p.m., the Director of Housekeeping was shown the findings in the dining cabinets. He said his department was responsible for cleaning these. He said they should not look like that and they should be cleaning the cabinets every Monday and Friday. On 4/22/25 at 9:24 a.m., the Director of Housekeeping said he had spoken in error, and the cabinets should have been cleaned on the weekend. He said it had been scheduled to be cleaned on the previous Sunday and it was missed. He said he had been aware of issues with bugs in the memory care unit and agreed leaving the cabinets with half eaten food and debris could attract bugs. On 04/23/25 at 09:43 a.m., the Administrator entered the Memory care unit, was shown the photographic evidence and walked through a few rooms to point out the findings. The Administrator said he had only been with the facility about a month and agreed the unit is old and could use room by room updates. He said half eaten food should not be in the cabinets and the dining room cabinets should not be left in that condition. He also said he would call pest control back in and that it had been an ongoing issue. The facility policy and procedure Work Orders documented Work orders outside of the service reports and equipment records are a mandatory means of maintenance communication. Work orders should be used and completed with priority classification noted by either the department head or the administrator. If upon examination of the job site, outside help is necessary this should be noted and sent to the administrator. On 4/21/25 at 8:00 a.m., during initial rounds, the following was observed: room [ROOM NUMBER] in the shared bathroom a urinal was stored on the handrail of the shared bathroom. The urinal was not labeled to identify the resident using the urinal. The bathroom door did not have a doorknob, only the whole in the door where it once was. Anyone who needed to use the bathroom would need to place their fingers in the hole and pull the door open and closed. The privacy curtain separating the two beds was soiled and had brown stains. room [ROOM NUMBER] had broken blinds on the window with several blinds missing. The corner of the wall next to the closet was chipped and cracked and the molding was pulling away from the wall. Rooms 329 and room [ROOM NUMBER] the closet door was missing on one side of the closet. On 4/22/25 at 8:43 a.m., Resident #75 was observed in his room in bed. He is noted with his feet pressed against the foot board of the bed. He said I'm 6'2 and I have asked for a bigger bed but I never got one. On 4/22/25 at 8:44 a.m., in an interview Licensed Practical Nurse Staff C said he observed the broken blinds in room [ROOM NUMBER] and said we place a concern for maintenance in the Tells system. On 4/22/25 at 8:46 a.m., the Assistant Director of Nursing (ADON) said she observed the broken blinds in room [ROOM NUMBER]. They are visible from the hallway of the nurse's station. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/22/25 at 8:48 a.m., the Regional Nurse Consultant said she spoke with maintenance regarding the broken blinds and missing closet doors. On 4/22/25 at 8:55 a.m., during an interview the ADON was notified of Resident #75's request for a longer bed. The ADON said the facility did not have bed extenders. Review of the documentation presented by the administrator showed no order had been placed for the blinds or closet doors. The documentation was a quoted price for the supplies. In a phone interview the supply company confirmed the facility made no purchase of the blinds or closet doors. On 4/22/25 at 9:30 a.m., during walking rounds with the Regional Plant Manager he confirmed the findings of the necessary building repairs On 4/22/25 at 12:35 p.m., observed Resident #102 in room [ROOM NUMBER]B. Resident #102 said the bifold door panel broke 3 months ago and the facility removed it. The resident said the missing panel has been that way for 3 months. The resident said it bothers her and does not like to have her clothing exposed. On 4/23/25 at 9:12 a.m., observed Resident #102's door panel was still missing. Observed 1/2 the clothing on hangers. On 4/24/25 at 8:47 a.m., during an interview with the Director of Nursing (DON) in room [ROOM NUMBER], she said the closet door should not be that way. On 4/24/25 reviewed the completed work order #4399 created on 12/3/24. Closet Door Broken in room [ROOM NUMBER]B. On 12/19/24, the status was updated as Set to Completed.