STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105882	A. BUILDING _____ B. WING _____	**08/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 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 and staff and resident interview the facility failed to maintain a functioning communication system in one (Ford unit) of three units in the facility in order to promptly meet the needs of the residents. The findings included: On 8/10/20 at 7:30 a.m., observation of the(NAME)unit revealed the following: 1.Resident #994 was in bed awake and alert. When the call button was pressed, the light did not come on. Certified Nursing Assistant (CNA) Staff P verified the call light was not working and the resident did not have a call bell to call for assistance. 2. Resident #991 was observed in bed repeatedly calling out loud for a nurse. On 8/10/20 at 7:50 a.m., Resident #991 said the call light has not been working, they are broken a lot. The resident said he did not have another means of communication but to yell out nurse when he needed something. Resident #991 continued to yell out nurse until 8/10/20 at 8:10 a.m., when a nurse entered the room. 3. On 8/10/20 at 7:53 a.m., Resident #990 was in bed. When the call button was pressed the light did not come on. Upon observation of the room CNA Staff O verified the resident did not have a call bell and would not be able to call for assistance. On 8/10/20 at 7:55 a.m., during an interview with CNA Staff O, she said the call lights have not been working for weeks but the residents were given a call bell and staff were instructed to make rounds every 15 minutes. She said staff was too busy and there is not enough time to make rounds every 15 minutes. 4. On 8/10/20 at 8:05 a.m., Resident #986 was observed in bed with 1/4 rails elevated bilaterally. The resident complained her spine hurt and she could not reach the call light to request pain medication. A call bell was observed on an overbed table located approximately 12 feet from the bed. The resident said she could not get up to reach it and call the nurse. Resident #986 also said her cup of water was on the table and she cannot reach it. 5. On 8/10/20 at 8:10 a.m., Resident #987 was observed in bed. She was alert and able to answer questions. She said the call light was not working and she did not have a call bell. Resident #987 said no one came in to check on her. 6. On 8/10/20 at 8:20 a.m., Resident #985 was observed in bed having breakfast. The call light was not functioning, and the resident said she did not have a call bell to call for assistance when needed. CNA Staff R searched the resident's room and verified Resident #985 did not have the means to call for assistance. On 8/10/20 at 8:30 a.m., the Administrator said the call lights were tripping. She said an outside company came out several times to fix the system, but they still malfunction intermittently. She said she had another company coming for a quote to replace the call light system on the Ford's unit. She said staff was instructed to make rounds every 15 minutes. 7. On 8/10/20 at 11:45 a.m., Resident #994 was observed in her room in a locked wheelchair next to the bedroom door. An overbed table with a call bell was approximately 15 feet from the resident. The call bell was not within reach of the resident. CNA Staff Q verified the observation of Resident #994 and confirmed the resident had no means to call staff for assistance when needed. 8. On 8/11/20 at 11:55 a.m., Resident #991 was observed in his room in a recliner. The resident did not have a call light or a call bell within reach. An overbed table with a call bell was observed behind the wheelchair. Resident #991 explained he was not able to move on his own, he was paralyzed and was barely able to move his fingers. The resident explained he always had to yell for assistance, and they don't always come timely. On 8/11/20 at 12:00 p.m., CNA Staff Q said he transferred Resident #991 into the chair and verified the call bell was not within reach. He moved the overbed table and placed it approximately 4 feet in front of the chair. Resident #991 said he was not able to extend his arms and reach the call bell. CNA Staff Q exited the room without ensuring the resident was able to reach the call bell.

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