

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105824	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Greenville Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 13455 W US Hwy 90 Greenville, FL 32331	

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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51235</p> <p>Based on observations and interviews and record reviews, the facility failed to maintain a safe, clean, comfortable homelike environment.</p> <p>The findings include:</p> <p>room [ROOM NUMBER]/201</p> <p>On 02/24/25 at approximately 11:49 AM an observation of a shared resident bathroom between rooms [ROOM NUMBERS] revealed a urine specimen collector was present on the floor next to the toilet. Closer observation revealed this urine specimen collector was unlabeled, unbagged, and contained a brown colored stain on the bottom and sides of the container.</p> <p>On 02/25/25 at approximately 11:10 AM, a follow up observation revealed the unlabeled, unbagged, and stained urine specimen collector remained on the floor next to the residents' toilet.</p> <p>On 02/25/25 at approximately 11:35 AM, an interview was conducted with Nurse A and CNA (Certified Nursing Assistant) I. The surveyor showed the staff the urine specimen collector on the floor of the resident's bathroom at this time. Staff A stated the urine collector should not be in the bathroom. She stated the facility had disposable urine collectors and that these were disposed after use. CNA I stated the process was to label a urine specimen collector with the resident's name and then bag and stored the urine</p> <p>30584</p> <p>General tour</p> <p>On 02/27/25 at 11:43 AM a tour of the facility was conducted with the Administrator. Observations of the general areas of the facility revealed floors that are worn and dirty. There was a buildup of dirt/debris in all of the corners throughout the facility. There were rusty and stained plumbing fixtures in resident bathrooms, scrapes and dirt and lack of fresh painting on all walls in the halls and resident rooms and resident bathrooms. There were rusty and chipped door jams throughout the facility.</p> <p>(continued on next page)</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>At this time, the Administrator confirmed all the maintenance concerns and stated that they still have problems with the Maintenance and Housekeeping contractors and confirmed the floors were very worn and appear dirty. There was a large area approximately 3ft by 3ft at the end of the 100 hall that is only concrete, missing numerous tiles. The Administrator stated they finally had to get a professional plumber in the building to unclog the pipes to address the problems the facility had with the toilets not flushing and numerous drains stopping up. The Administrator stated the plumbers had to go under the floor at the back of the 100 hall in order to make repairs. She did not address when they planned to replace the flooring in that spot. She also confirmed there were dirty floors and the corners appear to have dirt buildup. There is also the wall in the staff breakroom where they had to break through the wall to make repairs and the hole is still open and appears to have years of dirt/dust buildup. There are multiple doors to resident rooms and bathrooms throughout the facility that are peeling and appear unclean. There are multiple door jams that are rusty and falling apart throughout the facility. The walls were all scratched and/or dirty and in need of repair and paint throughout the facility. Bathroom floor tiles throughout the facility were worn and appear dirty or broken.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51235</p> <p>Based on record review and interviews, the facility failed to ensure the minimum data set (MDS) assessment accurately reflected the resident's status for 1 of 16 sampled residents. (Resident #30)</p> <p>The findings include:</p> <p>A review of Resident #30's electronic medical record revealed Resident #30 had a medical history significant for Major Depressive Disorder, Bipolar Disorder, and Schizoaffective Disorder.</p> <p>A review of Resident #30's annual Minimum Data Set (MDS), dated [DATE], indicated that Resident #30 was not considered to have a history of serious mental illness.</p> <p>An interview was conducted with the facility's Director of Nursing (DON) and Minimum Data Set (MDS) coordinator on 02/27/25 at approximately 10:00 AM. The DON and MDS coordinator independently reviewed Resident #30's record and confirmed the MDS was coded incorrectly. They confirmed the MDS should have been coded for serious mental illness.</p>

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>51235</p> <p>Based on record review, staff interviews, and review of facility policies and procedures, the facility failed to ensure residents with a diagnosis of serious mental illness for received a Level II Pre-admission Screening and Resident Review (PASARR) for 3 of 6 sampled residents reviewed for PASARR. (Resident #30, #1, #44)</p> <p>The findings included:</p> <p>A review of Resident #30's medical record revealed he had a medical history significant for Major Depressive Disorder, Bipolar Disorder, and Schizoaffective Disorder. The medical record failed to contain evidence that a Level II PASARR screening had been completed for Resident #30.</p> <p>A review of Resident #1's medical record revealed he had a medical history significant for Psychosis and Anxiety Disorder. The record failed to contain evidence that a Level II PASARR screening had been completed for Resident #1.</p> <p>A review of Resident #44's medical record revealed she had a medical history significant for Psychosis, Paranoid Schizophrenia, Major Depressive Disorder and Anxiety Disorder. The record failed to contain evidence that a Level II PASARR screening had been completed for Resident #44.</p> <p>An interview was conducted with the facility's Administrator on 2/27/25 at 10:45 AM. The Administrator independently reviewed the medical records for Residents #30, #1, and #44. She acknowledged that the identified residents did screening present in their records.</p> <p>A review of the facility policy, Preadmission Screening and Resident Review, dated 11/08/2021, states, The purpose of the procedure is to ensure residents with Serious Mental Illness (SMI) receive the care and services they need in the most appropriate setting.</p> <p>It is the responsibility of the center to assess and assure that the appropriate preadmission screenings, either Level 1 or Level II are conducted and results obtained prior to admission and placed in the appropriate section of the resident's medical record.</p> <p>If it is learned after admission that a PASARR Level II is indicated, it will be the responsibility of Social Services/designee to coordinate and/or inform the appropriate agency to conduct the screening and obtain the results.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45951</p> <p>Based on observations, interviews, and record review, the facility failed to maintain professional standards of practice regarding therapy services for 1 of 1 resident reviewed for range of motion. (Resident #1)</p> <p>The findings included:</p> <p>During a tour of the facility conducted on 02/24/25 at 11:30 AM, Resident #1 was observed lying in his bed. Closer observation revealed Resident #1 had severe contractures of both of his hands and was not wearing any splinting device on his hands. It was later noted there was a gray fabric splint hanging on the wall of the therapy room with Resident #1's name written on it in black marker. (photographic evidence obtained)</p> <p>Resident #1's record showed that he was admitted to the facility on [DATE]. Resident #1 had a medical history significant for Traumatic Brain Injury, Hemiplegia and Contractures of his right wrist, right hand, hips, and legs. A review of Resident #1's Quarterly Minimum Data Set, dated dated [DATE] revealed Resident #1 had a Brief Interview of Mental Status score of 11, indicating he had moderate cognitive impairment. A review of Resident #1's physician orders and Care Plans revealed there were no orders or care plans written regarding splint use or restorative nursing services.</p> <p>Additional observations were conducted on 02/25/25 at 9:02 AM, 02/25/25 at 3:45 PM, 02/26/25 at 9:05 AM, and 02/26/25 at 2:00 PM all of Resident #1 lying in his bed with no splints present on hands. The gray fabric splint remained on the wall of the therapy room throughout the survey week.</p> <p>An interview was conducted with the facility's Therapy Director on 02/26/25 at 1:51 PM. The Therapy Director confirmed Resident #1 was not receiving therapy services. She stated he had been discharged from Occupational Therapy on 09/25/24 and from Physical Therapy on 12/02/24. She stated this was due to his inability to progress toward therapy goals. She stated Resident #1 had no orders for splints and that the facility had no restorative nursing program. When showed the gray splint on the wall in the therapy room, the Therapy Director stated this was an old splint that was no longer being used because she had ordered new splints for Resident #1. When asked whose responsibility it was to ensure splints were being used, the Therapy Director stated the Certified Nursing Assistants could be trained to put on and take off splints. An observation was made in Resident #1's room and the Therapy Director found two hand splints in the bottom drawer of Resident #1's dresser. She confirmed the training of placing and removing hand splints was her responsibility as an Occupational Therapist. When asked about other splint use for Resident #1, the Therapy Director stated knee splints would be Physical Therapy's responsibility.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Physical Therapist (PT) was interviewed via telephone at 2:03 PM. The PT stated they attempted to straighten Resident #1's legs and apply splints but that it was uncomfortable for Resident #1 and the PT staff did not want to cause him pain. The PT stated the staff was verbally instructed to use pillows between Resident #1's calves and knees. When asked if an order was written for the use of pillows as a splinting technique, Staff D stated no order was written, that it was only conveyed to the CNAs verbally. When asked when he last assessed Resident #1 for PT services or to verify the staff was utilizing pillows between his calves and knees to prevent further contractures, the PT stated, it's been a minute, to be honest with you but that he would follow up on 02/27/25. The Therapy Director stated she would push to get restorative services started at the facility.</p> <p>Review of the facility's policy titled Restorative Nursing Services, dated 08/15/23 revealed the following:</p> <p>The center provides restorative nursing to encourage and enable residents to be as independent as possible based on their individual conditions and goals.</p> <p>The Interdisciplinary Care Team identifies residents who have a restorative need, which may include active range of motion, passive range of motion, and/or splint or brace assistance.</p> <p>Therapy will educate and train the Certified Nursing Assistants on strategies/interventions and/or techniques as it relates to each resident's restorative program.</p> <p>Staff designated as Restorative Aides and/or Certified Nursing Assistants will be educated on restorative techniques.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45951</p> <p>Based on observations and interviews, the facility failed to ensure two outside gates were secured in a locked fashion, failed to ensure residents did not have access to sharp instruments at bedside, and failed to ensure laundry lint was maintained properly all to ensure an environment free of potential accident hazards for all residents in the facility.</p> <p>The findings included:</p> <p>During a tour of the facility conducted on 02/25/25 at approximately 1:30 PM, it was noted that the maintenance gate outside the therapy room was unlocked and unsecured.</p> <p>An interview was conducted with the facility's Maintenance Director on 02/27/25 at 11:37 AM. He stated this gate was to be locked by the staff upon entering and exiting the external maintenance area. He confirmed the lock on the gate was not broken and that the staff were trained to use it.</p> <p>During a tour of the facility conducted on 02/27/25 at approximately 12:33 PM, the surveyors noted the gate outside the resident smoking area was unlocked and unsecured (photographic evidence obtained).</p> <p>An interview was conducted with the facility's Administrator on 02/27/25 at 1:30 PM. The Administrator observed the unlocked gate. The Administrator locked the gate and confirmed the lock on the gate was not broken and that the staff were trained to use it. The Administrator further stated the staff did not regularly use this gate to gain entrance into the facility from the parking area and she did not know why staff would have left the gate unlocked.</p> <p>During a tour of the facility conducted on 02/25/25 at 12:35 PM, the surveyor noted a pair of fingernail scissors in resident room [ROOM NUMBER] (photographic evidence obtained). Staff A, a Registered Nurse confirmed the residents were not supposed to have fingernail scissors present in their rooms. Staff immediately confiscated the scissors from the resident's room.</p> <p>A tour of the facility's laundry area was conducted on 02/27/25 at 11:34 AM with the facility's Maintenance Director. The Maintenance Director stated the facility's laundry was done in a separate building on the premises. Upon approaching the laundry building, two burned and rusted metal garbage cans were observed which were overflowing with bagged garbage and a large area of ash and burned residue on the ground directly next to the laundry building. The back wall of the building, next to the ash pile, was noted to be covered in a thick layer of lint (photographic evidence obtained). The Maintenance Director confirmed the facility routinely burned materials in this area, despite it being located directly next to the laundry building.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>45951</p> <p>Based on record review and interview, the facility failed to ensure sufficient nurse staffing numbers on a 24-hour basis to provide nursing care to all residents.</p> <p>The findings included:</p> <p>Review of the Payroll Based Journal (PBJ) staffing information provided by the facility for Quarter 1 of 2024 (October 1 through December 31) revealed that the facility failed to meet the minimum staffing requirements, causing them to trigger for excessively low weekend staffing.</p> <p>An interview was conducted with the facility's Administrator on 02/26/25 at 11:10 AM. The Administrator indicated she was aware that the facility had triggered for low staffing but that the previous owner was angry, so he didn't submit the information for 2 months. The Administrator did not indicate if she had attempted to provide additional information to the PBJ system when she learned that the information had not been properly submitted.</p>

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Post nurse staffing information every day.</p> <p>45951</p> <p>Based on observation, record review, and interview, the facility failed to maintain daily posted nurse staffing and failed to post the staffing in an area where it was easily visible to residents and their visitors. (photographic evidence obtained)</p> <p>The findings included:</p> <p>During a tour of the facility conducted on 02/24/25 at 11:58 AM, the posted nurse staffing was observed to be located on the wall behind the nurse's station desk, not in full view of residents and visitors. Closer observation revealed the night and day shift staffing were posted, but the evening shift was blank.</p> <p>During a tour of the facility conducted on 02/26/25 at 10:55 AM, it was once again noted that the posted nurse staffing was located on the wall behind the nurse's station desk, not in full view of residents and visitors. Closer observation revealed posted staffing was dated 02/25/25 and that the night and day shift staffing were posted, but the evening shift was blank.</p> <p>An interview was conducted at this time with Staff B, Registered Nurse. Staff B stated the staffing was posted daily by the facility's Director of Nursing (DON).</p> <p>An interview was conducted with the facility's DON on 02/26/25 at 11:00 AM. She stated the evening staff line was not filled in because she was going to fill it in when the staff came in for the evening shift. She stated she was unaware that the staffing was to be posted for the whole day. The DON was also asked why the staffing sheet was not posted where it was visible to all residents and visitors. The DON stated she was unaware that it was supposed to be posted for the residents and visitors to view.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45951</p> <p>Based on observations, interviews, and policy review, the facility failed to ensure medications were properly and securely stored and the facility failed to ensure proper and timely disposal of expired medications.</p> <p>The findings included:</p> <p>A blood glucose observation was conducted on 02/25/25 at 11:24 AM with Staff E, a Registered Nurse (RN), for Resident #8. Upon entering Resident #8's room, Staff E left her medication cart unlocked and unattended in the hallway. Following the medication administration observation, Staff E was asked what her process was for locking her medication cart between administering medications to her residents. Staff E stated she would typically lock her medication cart each time she entered a resident's room.</p> <p>A medication administration observation was conducted on 02/25/25 at 11:42 AM with Staff E, Registered Nurse (RN), for Resident #50. Staff E prepared 11 medications to administer to Resident #50. Upon entering Resident #50's room, Staff E placed the medications on the resident's dresser and walked away to wash her hands, leaving the medications unattended. Following the medication administration observation, Staff E was asked what her process was for washing her hands when administering medications to residents. Staff E stated she would typically take the medications to the sink with her when she washed her hands.</p> <p>On 02/26/25 at 8:54 AM, on the way to conduct a medication administration observation, Staff F, Licensed Practical Nurse (LPN) walked into room [ROOM NUMBER] to assist a resident. In doing so, Staff F left her medication cart unlocked and unattended in the hallway (photographic evidence obtained). Then Staff G, a Certified Nursing Assistant (CNA) and Staff H, another CNA, walked past the unlocked medication cart and into room [ROOM NUMBER] to assist with the resident. Continued observation revealed the facility's Director of Nursing (DON) walk up to the unlocked medication cart and place pudding into the cooler that was located on the top of the cart. During this observation, two unidentified residents also walked past the unlocked medication cart.</p> <p>A medication administration observation was conducted on 02/26/25 at 9:02 AM with Staff F, LPN for Resident #50. The nurse prepared 11 medications to administer to Resident #50. Upon entering Resident #50's room, Staff F did not lock the medication cart, leaving it unlocked and unattended in the hallway. Following the medication administration observation, Staff F was asked what her process was for locking her medication cart between administering medications to her residents. Staff F stated she would typically lock her medication cart each time she entered a resident's room.</p> <p>A medication room observation was conducted with Staff B, RN and Staff A, RN on 02/26/25 at 1:24 PM. They stated the over the counter medications were kept in the Clean Utility Room. While in the Clean Utility Room, it was found that there were six bottles of Vitamin C 250mg tablets which were expired with a date of expiration 12/2024 (photographic evidence obtained). Staff B and Staff A stated they would tell the facility's Administrator and the pharmacist about the expired medication bottles.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>45951</p> <p>Based on observation, record review, and interview the facility failed to ensure resident's confidential information was stored in a secure manner.</p> <p>The findings included:</p> <p>A tour of the facility's laundry area was conducted on 02/27/25 at 11:34 AM with the facility's Maintenance Director and Maintenance Assistant. The Maintenance Director stated he had been in his role for three or four months. The Maintenance Assistant stated he had been in his role for six to eight months. The Maintenance Director stated the facility's laundry was done in a separate building on the premises.</p> <p>Upon approaching the laundry building, it was noted that two burned and rusted metal garbage cans which were overflowing with bagged garbage. Upon asking the Maintenance Director what was in the garbage bags, he stated it was confidential documents waiting to be burned. Upon closer inspection, it was noted that the plastic bags were clear, unsealed, and open to air. It was confirmed the paperwork in the plastic bags contained confidential resident protected health information (PHI). Further observation revealed numerous pieces of paper loose on the ground which also contained resident's PHI along with a garbage bag filled with discarded medication packets, which also contained resident PHI (photographic evidence obtained). The Maintenance Director could not confirm how long this confidential information had been present outside the building.</p> <p>An interview was conducted with the facility's Administrator on 02/27/25 at 12:20 PM. She stated the garbage bags of confidential documents had been retrieved and brought inside the facility where they would stay until they were ready to be burned. The Administrator further confirmed it was the facility's policy that all confidential documents were burned on the premises and not collected by an outside company for destruction. She indicated she had not been aware that the documents were outside at that time. When asked if she had gone to confirm if all the documents had been retrieved, including the pieces of paper that were loose on the ground, she confirmed she had not.</p>		

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NAME OF PROVIDER OR SUPPLIER Greenville Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 13455 W US Hwy 90 Greenville, FL 32331	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>45951</p> <p>Based on observations, interviews, record and policy review the facility failed to maintain infection control standards regarding glucometer cleaning, handling and storing of laundry and linens, legionella testing, and resident's shared bathroom environments.</p> <p>The findings included:</p> <p>Blood Glucose monitoring</p> <p>A blood glucose observation was conducted on 02/25/25 at 11:24 AM with Staff E, a Registered Nurse, for Resident #8. Staff E stated each resident had their own glucometer that the staff kept in designated plastic containers within the medication carts. Staff E stated the nurses cleaned the glucometers before and after each glucose check. Staff E removed Resident #8's glucometer from its plastic container. She then retrieved a Clorox bleach wipe from the medication cart. She cleaned the meter with the Clorox bleach wipe and set the meter to air dry on top of the medication cart. Staff E did not don gloves or use a secondary wipe to disinfect the glucose meter during this observation. Staff E stated the meter would be left for 1-3 minutes to air dry before going into Resident #8's room to check the blood glucose level. When asked what the wet time was for the monitor, Staff E stated she did not understand the question and reiterated the monitor would be left to dry for 1-3 minutes. Following the blood glucose check and upon returning to the medication cart, Staff E retrieved a Clorox bleach wipe from the medication cart. She cleaned the meter with the Clorox bleach wipe and set the monitor to air dry on top of a tissue. Staff E did not don gloves or use a secondary wipe to disinfect the glucose meter during this observation. Staff E stated she would allow the monitor to dry for 1-3 minutes before returning it to its plastic container.</p> <p>Review of the manufacturer's instructions for the Assure Prism Multi Blood Glucose Monitoring System revealed the recommended contact time with a Clorox Germicidal Wipe was 1 minute. The manufacturer recommended the same steps as above for proper cleaning and disinfecting of the meter.</p> <p>Review of the facility's Skills Competency Assessment titled Glucometer shows that the proper steps for cleaning and disinfecting a blood glucose meter were as follows:</p> <p>Clean and disinfect the meter with disinfectant wipe per manufacturer recommended wet time. Follow the 2-step process for cleaning and disinfecting. Apply gloves and obtain a disinfectant wipe. With disinfectant wipe, clean the entire surface of the meter 3 times horizontally and 3 times vertically, invert the meter so the test strip is facing down and clean around the test strip port. Dispose of wipe. Obtain a new disinfectant wipe and repeat the procedure above to remove blood-borne pathogens. The surface remains wet per the wipe manufacturer's instructions. Wipe the meter dry with a paper towel after the recommended wet time. Remove gloves and perform hand hygiene.</p> <p>Laundry</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A tour of the facility's laundry area was performed on 02/27/25 at 11:34 AM with the Maintenance Director, Maintenance Assistant, and Staff J, Laundry Aid. The Maintenance Director stated he had been in his role for three or four months. The Maintenance Assistant stated he had been in his role for six to eight months. Staff J stated she had been working for the facility for many years. Photographic evidence was obtained of the following areas of concern.</p> <p>Upon entering the laundry building, it was noted in the secondary storage room a hole in the ceiling, approximately four to five inches in diameter with outdoor debris present/poking down into the room. When asked what he thought it was, the Maintenance Assistant stated, A rat's nest, I mean a bird's nest. In this secondary storage room, ten bags of resident clothing and personal belongings were piled on the floor along with an uncovered cart containing 21 items of clothing. When asked whose belongings these were, Staff J stated these were clothes and belongings left by residents who had been discharged from the facility or had passed away. She further stated the facility kept the belongings for 30 days for the families to collect. When asked to confirm how long the bags had been stored in this room, Staff J stated she did not know but that it had been more than 30 days.</p> <p>Upon entering the washing machine room, there were two washing machines there, one of which was broken. A water heater present next to the washing machine in the main room. Closer inspection revealed the water heater was unplugged. Staff J and the Maintenance Director were both unable to confirm if this water heater worked properly or for how long it had been unplugged. Staff J was able to confirm the bathroom she used to wash her hands, located next to the washing machine room, did not have hot water in the sink. The button for HOT was depressed on the washing machine and a load of laundry had recently finished. When asked if this load was washed on hot water, Staff J stated, no, I think it was a cold load. She was unable to confirm the button for hot water was pressed on the washing machine. Disposable gowns and gloves were hanging on the wall. Staff J confirmed she did not change these articles of personal protective equipment (PPE) between loads and confirmed she was not aware that she was supposed to. The floor throughout the building was noted to be a cement sub floor, not suitable for maintaining a clean environment for the laundry as it was not able to be properly cleaned. The Maintenance Director stated he swept the floor daily but that the staff walk in from outside and bring the dirt in with them.</p> <p>Upon entering the dryer room, there was only one dryer available. The light above the dryer was broken, leaving that corner of the room very dark and difficult to see. Wet clothing uncovered in a rolling laundry cart was observed. Staff J stated this laundry was clean and waiting to go into the dryer. Used disposable gowns and gloves were hanging on the wall. Staff J confirmed she did not change these articles of PPE between loads and confirmed she was not aware that she was supposed to. Three clean pillows were noted on top of a linen cart, uncovered. The rolling laundry carts that Staff J stated she used to move the laundry from the washing machines to the dryer and then to the folding table were made of metal. The carts had multiple areas of rust and no inner lining or top cover to protect the laundry. Staff J was unable to confirm when the carts were last cleaned. The folding table/area was noted to be discolored and had chipped laminate, causing the surface to be unable to properly clean.</p> <p>Legionella testing</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview was conducted with the facility's Maintenance Director and Maintenance Assistant on 02/27/25 at 12:30 PM regarding Legionella testing at the facility. The Maintenance Director stated he was not responsible for Legionella testing. The Maintenance Assistant stated he performed water flush and water temperature testing regularly. In reviewing the Legionella binder that was provided by the Maintenance Director, documentation of water flush testing and water temperature testing was reviewed. No evidence of Legionella testing from the past year was available. When asked, The Maintenance Director again stated he was not responsible for Legionella testing. The Maintenance Assistant stated he was unaware of Legionella testing that had been performed or was to be performed. He further stated he was unaware of any third-party company that may have been contracted with the facility to perform this testing, and he had not received any testing or results from anyone.</p> <p>Review of the facility's policy titled Legionella Risk Management Policy, stated:</p> <p>The purpose of this policy is to ensure that as far as possible all residents, staff, and visitors of this facility are protected from the incidence of Legionnaire's disease.</p> <p>The minimum standards to be met include: preparing Legionella Risk Assessments; preparation of an action plan for preventing or controlling the risk; implementation, management, monitoring, and recording of precautions to include regular inspections, microbiological monitoring, temperature checks, and flushing; appointment of a person to be managerially responsible for the water system.</p> <p>Weekly checks should include shower heads and ice machines.</p> <p>Monthly checks should include taps.</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>51235</p> <p>Based on record review and staff interview, the facility failed to ensure the influenza vaccination was administered to 1 of 5 residents sampled for vaccine review (Resident #48).</p> <p>The findings include:</p> <p>A review of Resident #48's medical record revealed that Resident #48 received education and signed his influenza vaccine consent on 12/13/2024, indicating he wished to receive the vaccination. Further review of Resident #48's medical record revealed no documentation that Resident #48 received the influenza vaccination.</p> <p>An interview was conducted with the Director of Nursing (DON) on 02/26/25 at approximately 2:50 PM. The DON confirmed Resident #48 had signed the consent form for influenza, but the vaccination was not administered. The DON stated the influenza vaccination would be given to Resident #48 as soon as it was received by the facility.</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep all essential equipment working safely.</p> <p>45951</p> <p>Based upon observation and interview, the facility failed to maintain the laundry room and shower room in safe operating conditions.</p> <p>The findings include:</p> <p>A tour of the facility's laundry area was performed on 02/27/25 at 11:34 AM. Photographic evidence was obtained of the following areas of concern.</p> <p>The tour of the facility's laundry area was conducted with the facility's Maintenance Director, Maintenance Assistant, and Staff J, a Laundry Aid. The Maintenance Director stated the facility's laundry was done in a separate building on the premises. The Maintenance Director stated he had been in his role for three or four months. The Maintenance Assistant stated he had been in his role for six to eight months. Staff J stated she had been working for the facility for many years. Upon approaching the laundry building, a large amount of garbage and debris was noted around the outside perimeter of the building. There was two burned and rusted metal garbage cans which were overflowing with bagged garbage and a large area of ash and burned residue on the ground directly next to the laundry building. The back wall of the building, next to the ash, was noted to be covered in a thick layer of lint. Six mattresses and 2 toilets were noted sitting behind a dumpster. There was also an incontinence brief, gloves, and other debris and garbage noted on the ground around the dumpster. Thirty eight wooden pallets were present along all sides of the laundry building, along with other pieces of wood and furniture, including an overturned picnic table and a dresser in stages of decay. There were also plastic storage bins, plastic crates, metal pipes, metal bins, an office chair, a Hoyer lift, wheelchairs, walkers, and other pieces of broken equipment noted around the perimeter of the building. Also noted next to the laundry building were fourteen plastic 5-gallon containers containing the remnants of laundry chemicals. The Maintenance Director could not confirm how long the broken equipment, pallets, and garbage had been present outside the laundry building. When asked how often the garbage and pallets were collected, the Maintenance Director stated, I can call the guy, he will come and get the stuff. However, the Maintenance Director and Maintenance Assistant were unable to confirm what company the facility contracted with to collect pallets and garbage.</p> <p>Upon entering the laundry building, there were two maintenance/storage rooms observed. Boxes were piled up to the ceiling in both rooms along with three broken lights. In the secondary storage room, a hole in the ceiling was noted, approximately four to five inches in diameter, with outdoor debris present/poking down into the room. When asked what he thought it was, the Maintenance Assistant stated, A rat's nest, I mean a bird's nest. In this secondary storage room, there was observed ten bags of resident clothing and personal belongings piled on the floor along with an uncovered cart containing 21 items of clothing. When asked whose belongings these were, Staff J stated these were clothes and belongings left by residents who had been discharged from the facility or had passed away. She further stated the facility kept the belongings for 30 days for the families to collect. When asked to confirm how long the bags had been stored in this room, Staff J stated she did not know but that it had been more than 30 days.</p> <p>(continued on next page)</p>

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Upon entering the washing machine room, the surveyors noted two washing machines, one of which was broken. When asked to confirm how long this washing machine had been broken, the Maintenance Assistant stated it had been broken for at least eight months. When asked if this washing machine was being fixed, replaced, or removed, the Maintenance Director was unable to confirm the status or plan for the broken washing machine. Staff J stated she felt the laundry staff was able to keep up with the laundry demand with the remaining working washing machine. She further stated they had a second washing machine located in a room that was off to the side. Upon entering the additional room, the surveyor noted two urinals, which contained visible residue of laundry detergent, and a water pitcher. When asked what these were used for, the Maintenance Director stated, they only use this machine in an emergency. When asked again if the staff used these to place laundry chemicals in this washing machine, the Maintenance Director confirmed the staff used the urinal bottles to measure the laundry chemicals. He stated, we tell them to just measure like you would at home. A water heater was present next to the washing machine in the main room. Closer inspection revealed the water heater was unplugged. Staff J and the Maintenance Director were both unable to confirm if this water heater worked properly or for how long it had been unplugged. Staff J was able to confirm the bathroom she used to wash her hands, located next to the washing machine room, did not have hot water in the sink. The surveyors noted the button for HOT was depressed on the washing machine and that a load of laundry had recently finished. When asked if this load was washed on hot water, Staff J stated, no, I think it was a cold load. She was unable to confirm why the button for hot water was pressed on the washing machine. Three ceiling lights were noted to be broken in the washing machine room. Also, it was noted that used disposable gowns and gloves were hanging on the wall. Staff J confirmed she did not change these articles of personal protective equipment (PPE) between loads and confirmed she was not aware that she was supposed to. The floor throughout the building was noted to be a cement sub floor, not suitable for maintaining a clean environment for the laundry as it was not able to be properly cleaned. The Maintenance Director stated he swept the floor daily but that the staff walk in from outside and bring the dirt in with them. Behind the washing machines, a large buildup of lint, debris, rust, and garbage, including food bags, glasses, towels, spoons, and plumbing parts, was noted. There was also a large buildup of dirt, dust, and lint on the washing machines, fan, wiring, and water heater. The Maintenance Director was unable to confirm when these areas were last cleaned.</p> <p>Upon entering the dryer room, only one working dryer was observed. The light above the dryer was broken, leaving that corner of the room very dark and difficult to see. There was a bracket attached to the ceiling for a smoke detector, but no smoke detector was attached. There was wet clothing uncovered in a laundry cart. Staff J stated this laundry was clean and waiting to go into the dryer. Upon assessing the dryer drum, a large buildup of melted/burned brown and multi-colored substances was observed. The Maintenance Director was unable to confirm when the dryer drum was last cleaned. A moderate buildup of lint and debris was noted in the dryer lint area. Used disposable gowns and gloves were hanging on the wall. Staff J confirmed she did not change these articles of PPE between loads and confirmed she was not aware that she was supposed to. Three clean pillows were noted on top of a linen cart, uncovered. The rolling laundry carts that Staff J stated she used to move the laundry from the washing machines to the dryer and then to the folding table were made of metal. The carts had multiple areas of rust and no inner lining or top cover to protect the laundry. Staff J was unable to confirm when the carts were last cleaned. The folding table/area was noted to be discolored and had chipped laminate, causing the surface to be unable to properly clean.</p> <p>Utility room/shower room</p> <p>(continued on next page)</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A tour of the facility's soiled utility room and shower room was conducted on 02/27/25 at 12:30 PM with Staff F, Licensed Practical Nurse. Photographic evidence was obtained of the following areas of concern.</p> <p>Upon entering the soiled utility room, the surveyors noted the hot water in the handwashing sink did not work. The cold water ran yellow/rusty for approximately 5 minutes before clearing. Noted under the sink, along with cleaning chemicals, were two tube feeding pumps. Staff F stated she thought these were broken but could not confirm. On the countertop, nine different pieces of equipment. Staff F stated the staff placed equipment in this room that needed to be cleaned before it went back to storage and for resident use but could not confirm how long these pieces of equipment had been in the room.</p> <p>Upon entering the shower room, five cardboard boxes were observed stacked on the floor. Above the boxes was a wall cabinet which was chipping and decaying. There was a large amount of rust noted within the cabinet. Next to the toilet in this room, the toilet paper holder contained a large amount of rust. The wall above the toilet paper holder had a large amount of black substance present. A shower chair was pushed against the wall of the shower room. Staff F stated this shower chair was broken and missing a piece that allowed the staff to put the back of the chair in different positions. She further stated that, because the chair was missing this piece, it was very uncomfortable for the residents who needed to use it for showering because it laid all the way back with no way for the staff to change/lock the chair into a different position so a resident could be more comfortable. She stated there were no other shower chairs in the facility for the staff to use.</p>		