STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105824	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenville Nursing and Rehab Center	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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and policy review, the facility failed to store resident food brought in from outside the facility in accordance with professional standards for food service safety.The findings include:On 5/13/26 at 2:45 PM, Staff C (Certified Nursing Assistant (CNA)) was interviewed about where resident food is stored when brought in from outside the facility. Staff C stated that the facility does not have a resident nourishment room and that any foods brought in for residents are stored in the staff break room refrigerator. When asked if the staff food is stored in the same refrigerator as the residents, Staff C confirmed that it was.On 5/13/26 at 2:45 PM, it was observed that the staff breakroom refrigerator contained several partially open food containers, many not dated. No thermometer was present in the refrigerator or freezer and no temperature logs for the refrigerator or the freezer was available. (Photographic evidence obtained)On 5/13/26 at 3:15 PM, the Administrator was interviewed about why resident food was stored in the staff's breakroom refrigerator. The Administrator stated that the kitchen staff used a refrigerator located in the hallway outside the kitchen for residents' evening snacks. However, since staff keep this refrigerator locked, they were not taking the time to retrieve the keys to use that refrigerator to store resident food brought in from outside. Therefore, the resident's food was put in the staff refrigerator for convenience.The facility's policy Foods Brought in By Family/Visitors (undated), states, 5. Perishable foods must be stored in re-sealable containers with tightly fitting lids in the refrigerator (used for resident items). Containers must be labeled with the resident's name, the item and the use by date. 6. The facility staff, in charge of cleaning the common area refrigerator, is responsible for discarding perishable foods on or before the use by date/3days.The facility's policy Food Storage - Cold (effective 10/18/18), states, 2. Perishable foods are to be maintained at a temperature of 41 F or below 4. Temperatures are to be recorded daily. 5. Cold foods are to be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross-contamination.

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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(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 - Few	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 observations, staff interviews, and record reviews, the facility failed to provide a safe and comfortable environment by failing to ensure adequate insulation was placed around window air conditioner for 1 of 1 resident room sampled. (room [ROOM NUMBER])Additionally, based on observations, staff interviews, resident interviews, and record reviews, the facility failed to provide residents with a safe, clean, comfortable, and homelike environment due to inadequate access to hot water in nine of twenty resident rooms reviewed.The findings include: 1. On 05/11/2026 at 12:00 PM, it was observed that, in regards to room [ROOM NUMBER]'s window air conditioning unit (a/c unit), one resident's bed was observed to be positioned directly below the window. The window around the ac unit was open approximately 3 inches. A crumpled curtain had been placed on the windowsill. The crumpled curtain was not preventing the cold air from escaping or insects from entering the room. The resident stated being unable to recall how long the window unit had been without insulation. On 05/12/2026 at 9:30 AM, a follow up observation was made on the window a/c unit in room [ROOM NUMBER] as it was raining during the observation. The head of the resident's bed was observed to be damp with rain entering the window. The resident was asleep in the bed, scrunched down lower on the mattress to avoid the damp area. On 05/12/2026 at 2:46 PM, the room [ROOM NUMBER] window a/c unit was reviewed with the Maintenance Director. Upon observation, the Maintenance Director stated not being aware of the issue and that insulation would be placed immediately. When asked how staff request maintenance service, he stated a request form is kept on housekeeping carts and at the nurses' station. On 05/12/2026 at 3:00 PM, an interview was performed with Staff B (Housekeeping). When asked about room [ROOM NUMBER]'s air conditioning unit, Staff B stated that a request had been submitted to maintenance about the lack of insulation around the ac unit several weeks ago. On 05/12/2026 at 3:05 PM, Staff A (Licensed Practical Nurse) was interviewed about the process that nursing staff use to report environmental concerns requiring repair. Staff A stated that maintenance requests are kept in a binder at the nurses' station. Staff A stated she was aware of room [ROOM NUMBER]'s window a/c unit and that the resident had kicked out the insulation panel for the a/c unit about a week ago and that a request had been put in for maintenance to replace the insulation. 2. On 5/11/2026 at 11:40 AM, it was observed that eight resident room sinks did not provide hot water after the hot water valve remained fully open for two minutes. (Rooms 200-203, 205-208). Additionally, in room [ROOM NUMBER], the sink faucet was not functioning at all. On 5/12/2026 at 3:13 PM, maintenance repaired the faucet in room [ROOM NUMBER]; however, the faucet still did not dispense hot water. After the hot water valve remained open for one and a half minutes, the water remained cold. On 5/13/2026 at 9:07 AM, one of the affected residents stated during an interview that staff must leave the water running for approximately 20 minutes or longer before the hot water tap finally (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	produces hot water. On 5/13/2026 at 9:28 AM, a review of Maintenance Request Tickets revealed no documented reports related to hot water issues. On 5/13/2026 at 9:30 AM, the Maintenance Director measured the water temperature from the hot water faucet in room [ROOM NUMBER] using an analog temperature probe. The initial temperature measured 60 degrees F. A second reading taken at 9:40 AM measured 68 degrees F. (Photographic evidence obtained.) On 5/13/2026 at 9:41 AM, the Maintenance Director stated during an interview that he was unaware of any reported hot water issues within the facility. On 5/13/2026 at 1:10 PM, members of the Resident Council stated during an interview that the shower's hot water valve must remain on for six to seven minutes before hot water is dispensed. On 5/13/2026 at 4:05 PM, Staff F, a Certified Nursing Assistant (CNA), stated during an interview that she was unaware whether anyone had reported the hot water issue. Staff F further stated that staff must leave the shower hot water valve open for two to three minutes before hot water is dispensed. Staff F stated that the amount of time required for hot water to dispense depends on the room's location in the hallway. On 5/13/2026 at 4:07 PM, Staff G, another CNA, stated during an interview that staff had reported the hot water issue to Maintenance, although Staff G could not recall when the report was made. Staff G further stated that the hot water valve must remain open for three to five minutes before hot water is dispensed and that the delay varies depending on the room's location in the hallway.