STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255173	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenburney Health Care and Rehabilitation Center	555 John R. Junkin Drive Natchez, MS 39120

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 43283 Based on observation, interview, record review, and policy review, the facility failed to ensure a resident's right to dignity and communication by not providing an accessible call light for one (1) of twenty (20) sampled residents (Resident #169). Findings included: A review of the facility ' s policy titled Resident Rights with an effective date of 11/30/14 revealed .The facility will ensure that the resident is not deprived of his/her rights . A resident shall be treated with dignity and respect . On 03/24/25 at 11:45 AM, during an observation and interview, Resident #169 was in bed with a touch call light at the foot of the bed. The resident explained he could not use that call light, as he was unable to raise his chin or head to activate the button. He stated he had experienced long wait times for staff assistance with repositioning. On 03/24/25 at 4:10 PM, during an observation and interview with Certified Nurse Aide (CNA) #1, observed Resident #169's push call light lying on the floor. CNA#1 stated this was her first time working with the resident and confirmed call lights are to remain within the resident's reach at all times. Resident #169 told her he could not use the type of call light provided. On 03/25/25 at 2:25 PM, during an interview with CNA #3, she explained that it was her first day working with the resident. She had reviewed the resident's medical record and spoken with the nurse regarding care. She confirmed the resident told her he could not use the call light due to paralysis, but the CNA stated she had not yet looked at the resident's call light. On 03/25/25 at 3:30 PM, Resident #169 was observed lying in bed. He explained he had not been provided with a call light he could use. On 03/26/25 at 2:45 PM, Resident #169 was again observed in bed. He explained that he still did not have an accessible call light and was dependent on staff checking in on him. He said his roommate sometimes helped at night, but during the day he had no assistance. The call light was observed lying on the floor between the two beds. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/26/25 at 4:10 PM, during an interview and observation with Licensed Practical Nurse (LPN) #2, she confirmed the resident's call light was lying on the floor and not within reach. She stated she was unaware of any other call light options at the facility besides the regular and touch button types. The resident explained that at previous facilities he used a blow-call light. On 03/27/25 at 10:00 AM, during an interview with Social Services #1, she stated she was not aware the resident had requested a room closer to the nurse's station or that he had no call light he could use. On 03/27/25 at 11:50 AM, during an interview with the facility Nurse Consultant, she asked whether the resident was paralyzed and stated she had not been informed that he needed a blow-call light. On 03/27/25 at 12:40 PM, during a phone interview with Registered Nurse (RN) #2, the Weekend Supervisor for Night Shift, she confirmed she provided the resident with a push button call light but did not assess whether the resident could use the touch button. She stated the resident was admitted as a paraplegic and could not use his hands. A record review of Resident #169's Admission Record revealed the facility admitted the resident on 03/22/25 with diagnoses including Functional Quadriplegia. A record review of Resident #169's Admission Data Collection dated 03/22/25 revealed the resident was alert and oriented to person, place, and time, with memory noted as okay. The assessment noted contractures and paralysis.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 48669 Based on observation, interview, record review, and facility policy review, the facility failed to ensure residents' rights to a clean, safe, homelike environment for three (3) of (20) sampled residents, as evidenced by unclean floors and bathrooms in resident rooms (Resident #11 and Resident #44) and improper handling of personal belongings (Resident #60). Findings include: A record review of the facility policy, Cleaning and Disinfection of Environmental Surfaces, revised 8/19, revealed, Policy Statement . Environmental surfaces will be cleaned and disinfected according to current CDC (Centers for Disease Control) recommendations for disinfection of healthcare facilities and the OSHA (Occupational Safety and Health Administration) Bloodborne Pathogens Standard . Policy Interpretation and Implementation . 1 . 9. Housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled. 10. Environmental surfaces will be disinfected (or cleaned) on a regular basis (e.g., daily, three times per week) and when surfaces are visibly soiled . A review of the facility policy, Your Rights with no date, revealed, Dignity and Self-Determination . You have the right to: Be treated with consideration . Receive reasonable accommodation of your individual needs . Keep and use your personal possessions . Resident #11 On 03/24/25 at 11:25 AM, during an observation and interview with Resident #11, the floor in his room was noted to be dirty with dried food smeared on both his side and his roommate's side of the room. The resident stated the room was filthy and had been that way since his admission. He added that it smelled like urine and reported that when he requested cleaning, staff would ignore him. An observation of the resident's bathroom revealed dried fecal matter inside the toilet bowl and dried urine stains. On 03/24/25 at 1:11 PM, during an interview with the Laundry and Housekeeping Supervisor, she stated that the housekeeping department was fully staffed and that staff work Monday through Friday from 7:00 AM to 2:30 PM. She explained that cleaning is completed during the first half of the shift and then staff return after lunch to touch up rooms, including bathrooms and trash cans. She confirmed that all rooms should have been cleaned by the time of the interview. She walked with the State Agency (SA) to Resident #11's room and confirmed the floor had dried food smeared on it and the bathroom toilet contained dried fecal material. A record review of Resident #11's Admission Record revealed the facility admitted the resident on 01/17/2025 with diagnoses including Unspecified Hearing Loss and Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting the Right Dominant Side and Abnormalities of Gait and Mobility. (continued on next page)

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	255173	A. Building B. Wing	03/27/2025

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident #11's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/24/25 revealed a Brief Interview for Mental Status (BIMS) score of 99, which indicated the resident was rarely or never understood. Resident #44 On 03/24/25 at 12:01 PM, during an observation and interview with Resident #44, the resident's room floor was observed to be dirty with trash on the floor and full trash cans. The resident stated the room was often like that. He also reported that he had three (3) pairs of size 40P pants that were sent to the laundry and never returned. He stated his brother had recently purchased the pants, and when he notified laundry staff, they stated they would look for the items, but he had not received any further information. On 03/24/25 at 1:11 PM, during an observation and interview with the Laundry and Housekeeping Supervisor of Resident #44's room she confirmed that the floor was very dirty and had trash scattered throughout. The supervisor stated she was unsure why the rooms had not been cleaned, as they were supposed to be done by that time. On 03/26/25 at 3:16 PM, during an interview with Resident #44's Resident Representative, he stated he visits monthly due to living out of town. He reported that during his visits, the facility was visibly dirty, with trash on the floors and debris stuck to the floor. He stated the bed sheets often appeared unclean and that he had seen roaches in the facility. On 03/27/25 at 9:01 AM, during an observation and interview with Resident #44, the resident stated that the floors were cleaner but added, That's only because you're here. Once you leave, it'll go back to how it was. A record review of Resident #44's Admission Record revealed the facility admitted the resident on 02/11/2022 with diagnoses including Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side. A record review of Resident #44's quarterly MDS with an ARD of 12/4/24 revealed a BIMS score of 12, which indicated the resident was cognitively intact. On 03/27/25 at 9:30 AM, during an interview with the Administrator, he stated that he expects the facility to be a homelike environment. He explained, We keep our homes clean, so this is the residents' home and should be kept clean as well. Resident #60 A record review of Resident #60's Admission Record revealed the facility admitted the resident on 01/17/25 with diagnoses including Idiopathic Neuropathy and Abnormalities of Gait and Mobility. A record review of the MDS with an ARD of 02/08/25 revealed a BIMS score of 10, which indicated moderate cognitive impairment. The resident could participate in interviews. (continued on next page)

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	255173	A. Building B. Wing	03/27/2025

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/27/25 at 11:09 AM, in an interview with Resident #60, she stated that staff had not replaced her missing gray pants or her black pajama shirt with a bear design. She explained she had sent both items to the laundry after spilling ice cream on them, but they never came back. She stated she informed the Laundry Aide, who told her she would look for the clothing but never provided an update. Resident #60 expressed sadness about the missing clothing, especially since she had not worn the new pants much and felt that her personal belongings were not valued. On 03/27/25 at 11:12 AM, during an interview with a Laundry Aide, she confirmed that Resident #60 reported missing items to her. She stated she searched for them and told the resident she could not locate them. She also reported the issue to her supervisor. On 03/27/25 at 11:15 AM, during an interview with the Laundry and Housekeeping Supervisor (LHS), she stated she was only aware of the missing pajama shirt. She reported searching for the item without success. When asked about the next step, she acknowledged that the incident should have been reported to the Director of Nursing (DON) or the Administrator, but she had not done so. She stated that had she followed proper protocol, the items may have been replaced. She acknowledged that the loss of personal items could cause distress to the resident. On 03/27/25 at 11:28 AM, during an interview with the Administrator, he stated he had not been informed of the missing items. He confirmed that if it had been reported, the facility would have replaced the missing clothing.

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	255173	A. Building B. Wing	03/27/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 41680 Based on observation, interviews, record reviews, and facility policy review, the facility failed to provide a resident who was unable to carry out activities of daily living (ADLs) with the necessary services to maintain good grooming and personal and oral care for one (1) of (20) sampled resident reviewed for personal hygiene and grooming, Resident #67. Findings included: A review of the facility ' s policy titled Activities of Daily Living, dated 02/01/22, revealed Policy: To encourage resident choice and participation in activities of daily living (ADL) and provide oversight, cuing, and assistance as necessary. ADL includes bathing, dressing, grooming, hygiene, toileting . On 03/24/25 at 12:38 PM, during an interview and observation, Resident #67 was observed lying in bed with a moderate amount of gray hair under her chin. She stated she wanted her chin hair shaved and reported her last shower was on Thursday. She stated she used to receive bed baths three (3) times per week. On 03/25/25 at 8:55 AM, during an observation, Resident #67 was observed lying in bed with her eyes closed. A strong odor of urine was noted in the room. On 03/25/25 at 3:15 PM, during an interview and observation, Resident #67 was observed with visible hair on her chin. A faint odor of urine was again noted in the room. The resident stated she had not received a bath that day. On 03/27/25 at 10:10 AM, during an interview, Resident #67 stated she would not receive a bath or be shaved until later that evening. On 03/27/25 at 2:33 PM, during an interview, Resident #67 stated that no staff had asked her about receiving a bed bath or shower during the current week. On 03/28/25 at 5:28 PM, during an interview, the Corporate Nurse confirmed she was aware of the care concerns related to Resident #67. A record review of Resident #67's Admission Record revealed the facility admitted the resident on 2/25/25 with diagnoses including Muscle Weakness, Other Reduced Mobility, and Lack of Coordination. A review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/07/25 revealed a Brief Interview for Mental Status (BIMS) score of 12, indicating the resident's cognition was moderately impaired. Section GG documented that Resident #67 required total assistance/dependent for bathing and showering. (continued on next page)

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	255173	A. Building B. Wing	03/27/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #67's Comprehensive Care Plan revealed no documentation related to refusals of care. The care plan indicated the resident required substantial to maximal assistance with activities of daily living.

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	255173	A. Building B. Wing	03/27/2025

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43283 Based on observation, interview, and record review, the facility failed to provide sufficient nursing staff to meet the needs of the residents for one (1) of (20) sampled residents, with the potential to affect all residents, Resident #67. Findings included: A record review of a signed statement, undated, from the Interim Administrator revealed: Facility staffs according to census, acuity and/or facility assessment based on resident needs. A review of the Facility assessment dated [DATE] revealed: .Evaluation of overall number of facility staff needed to ensure a sufficient number of qualified staff to meet each resident ' s needs . Licensed nurses providing direct care equaled 9, Nurse Aides equaled 21, Other Nursing personnel (e.g., those with administrative duties) equaled 3 . Describe your general staff plan to ensure that you have sufficient staff to meet the needs of the residents at any given time . Director of Nursing (DON) . 1 Registered Nurse (RN) DON . 1- RN as Assistant DON (ADON) . 1 Staff dev. Licensed Practical Nurse (LPN) . 1 wound care LPN . RN Charge 7-3 (1) 3-11 (1) 2 LPN days and evening and 2 LPN nights . Direct care staff days 8 . evening 7 . nights 6 . Resident #67 On 03/24/25 at 12:38 PM, during an interview and observation with Resident #67, she was observed lying in bed with visible hair under her chin. The resident stated she wanted her chin hair shaved and explained that her last shower was on the prior Thursday. The room had a strong odor of urine. She stated she used to receive bed baths three times per week. A review of Resident #67 ' s Admission Record revealed an admitted [DATE] with diagnoses including Muscle weakness, other reduced mobility, and Lack of coordination. A review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/07/25 revealed a Brief Interview for Mental Status (BIMS) score of 12, indicating the resident was cognitively intact. Section GG revealed the resident was dependent for bathing and showers. On 03/24/25 at 4:10 PM, during an interview with Certified Nurse Aide (CNA) #2, she stated she worked part-time on both the 7:00 AM-3:00 PM and 3:00 PM-11:00 PM shifts. She explained that the number of CNAs varied by day and shift, ranging from as few as three (3) to as many as ten (10). When only three CNAs were present, it was difficult to check and change residents every two (2) hours, and residents had to wait longer for care. (continued on next page)

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	255173	A. Building B. Wing	03/27/2025

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/25/25 at 9:10 AM, during an interview with CNA #3, she reported caring for an average of sixteen (16) residents per shift, depending on staffing. She explained the average number of CNAs was five (5), but there were days with fewer. On those days, residents often had to wait longer for care and might not receive scheduled showers. On 03/25/25 at 1:10 PM, during an interview with CNA #6, she stated she typically worked eight (8)-hour shifts but had recently worked more twelve (12)-hour shifts due to staffing shortages. She cared for six (6) to (10) residents per shift. She reported that residents may have to wait longer than two hours to be changed or repositioned when staffing was low, and showers were sometimes delayed when a designated shower aide was unavailable. On 03/25/25 at 2:55 PM, during an interview with Licensed Practical Nurse (LPN) #3, she reported working (12)-hour shifts on a rotating schedule. She cared for over (30) residents and sometimes more, depending on the census. She explained she had worked extra hours and days to help cover due to ongoing staffing shortages among nurses and CNAs. On 03/26/25 at 8:24 AM, during an interview with LPN #2, she stated she worked in medical records but was currently working the medication cart due to low staffing. She stated, I worked last night, went home for a couple of hours, and I'm back this morning. On 03/26/25 at 10:05 AM, during an interview with CNA #4, she reported working all shifts and was called in to work that day. She cared for approximately (15) residents per shift. She stated that some days there was a designated shower aide and other days there was not. She explained that due to low staffing, residents had to wait extended periods for care and noted that only small gloves were available, which made providing care difficult. On 03/26/25 at 11:50 AM, during an interview with CNA #5, she stated she worked part-time, primarily on the 7:00 AM-3:00 PM shift. She reported having over (20) residents on some shifts when only (3) CNAs were present. On those days, residents were often not gotten out of bed and had to wait extended periods to be changed. On 03/26/25 at 12:48 PM, during an interview with CNA #7, who also worked in restorative care, she stated that due to CNA shortages, she worked on the hall in addition to her restorative and whirlpool duties. She worked as a restorative aide (2) to (3) days per week and as a floor CNA the remainder of the week. On 03/26/25 at 4:10 PM, during a follow-up interview with LPN #2, she confirmed she had worked the cart the night before from 7:00 PM to 2:00 AM and returned the next morning to work the cart again. She stated there was no regular nurse scheduled for that rotation, and the on-call nurse often had to work the cart. On 03/27/25 at 11:30 AM, during an interview with the Nurse Consultant, she stated the Director of Nursing (DON) had been off that week due to a family emergency. She confirmed that the DON created the nursing schedule and the Staff Developer created the CNA schedule. (continued on next page)

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	255173	A. Building B. Wing	03/27/2025

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/27/25 at 11:50 AM, during an interview with LPN #5, she confirmed she had worked full-time in her current role since April 2024 and part-time at the facility for over (2) years. She confirmed that she created the CNA schedule and the DON created the nurse schedule. She stated staffing was short and that many staff only worked a few hours to assist as needed. She explained that LPNs usually worked twelve (12)-hour shifts and CNAs worked eight (8)-hour shifts. She confirmed that the Medical Records nurse had worked both night and day shifts due to call-ins, which was a frequent pattern. She reported that residents had complained about waiting long periods to be changed or cleaned due to low staffing. A review of the staffing schedules and staffing grids for March 2025 revealed the following: On 03/06/25, three (3) CNAs were assigned to care for (67) residents on the 7:00 AM-3:00 PM shift. On 03/09/25, only two (2) CNAs were assigned to care for (67) residents on the 11:00 PM-7:00 AM shift. On 03/21/25, 03/22/25, and 03/23/25, only (3) CNAs were scheduled for the 7:00 AM-3:00 PM shift, with resident counts ranging from (67) to (69). On 03/15/25, three (3) CNAs were scheduled for the 3:00 PM-11:00 PM shift and (2) CNAs for the 11:00 PM-7:00 AM shift, for (67) residents. On 03/27/25 at 2:00 PM, during an interview with the Interim Administrator, he stated he had only been at the facility for three (3) weeks and was still learning about the facility, staff, and residents. He explained that he expected the facility to follow federal staffing regulations and conduct staffing assessments.

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	255173	A. Building B. Wing	03/27/2025

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43283 Based on interviews and record review, the facility failed to ensure the presence of a Registered Nurse (RN) for at least eight (8) hours a day, seven (7) days a week as required, for eight (8) of (19) days reviewed. Findings included: On 03/27/25 at 11:50 AM, during an interview with Licensed Practical Nurse (LPN) #1, she explained that she had been told by the facility's Nurse Consultant that the Director of Nursing (DON) could be counted as the RN and that she, as the LPN, could also be included on the staffing grid. She stated that at a previous facility, she was not allowed to count the DON or herself on the staffing report unless they completed direct care hours. She confirmed that the DON is the only RN in the facility Monday through Friday, although another RN occasionally serves as Charge Nurse. LPN #1 explained that the DON often counts herself as both the Charge Nurse and the DON and helps where needed, including acting as Charge Nurse when no one else is available. A record review of the facility's staffing grids and nurse/Certified Nursing Assistant (CNA) schedules for the week of 03/06/25 through 03/24/25 revealed eight (8) days where no RN coverage was documented for a full 24-hour period. On 03/27/25 at 12:20 PM, during an interview with the Nurse Consultant, she explained that she was not aware the DON had been counting herself as the Charge Nurse during the week. She believed the DON could be counted if the census was low, regardless of licensed bed capacity. She also believed the Staff Development Nurse counted toward RN coverage. The Nurse Consultant confirmed that on the days in question, the facility's census was greater than sixty (60). On 03/27/25 at 2:00 PM, during an interview with the Interim Administrator, he explained that he had only been in the facility for three (3) weeks and was still learning the facility's operations, staff, and residents. He stated that he expected the facility to follow federal staffing regulations and its own staffing assessment. A review of a signed statement, undated, provided by the Interim Administrator revealed Facility staffs according to census, acuity and/or facility assessment based on resident needs. A review of another signed statement from the Interim Administrator revealedQuality of Care: Facility follows policy related to the specific area of care. A review of the facility's Facility assessment dated [DATE] revealedEvaluation of overall number of facility staff needed to ensure a sufficient number of qualified staff to meet each resident's needs . Licensed nurses providing direct care equaled 9, Nurse Aides equaled 21, Other Nursing personnel (e.g., those with administrative duties) equaled 3 . Describe your general staff plan to ensure that you have sufficient staff to meet the needs of the residents at any given time . DON . 1 RN DON .