STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495391	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenburnie Rehab & Nursing Center	1901 Libbie Ave Richmond, VA 23226

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation and staff interview, the facility staff failed to uphold one resident's personal privacy to promote dignity for one resident (Resident #3-R3) in a survey sample of nine residents. The findings included: For R3, the facility staff failed to ensure the resident was covered and not exposed to protect her dignity and personal privacy. On 6/24/26 at 1:10 PM, during observations of the lunch meal tray distribution, three staff walked past R3's room to retrieve meal trays from the cart and began distributing meals to residents on the hallway. While observations were being made a resident could be heard making moaning noises, the surveyor went to see what was going on. R3 was observed sitting in a wheelchair at the bedside, door to the room open and no privacy curtain pulled. Full visual observations of the resident could be made from the hallway and noted that R3's full chest and breasts were exposed. Three staff continued distributing meal trays on the unit and two male residents self-propel down the hallway past R3's room. Two nursing staff and dietary manager walk past R3's room to take the meal tray cart to another hallway and did not intervene. On 6/24/26 at 1:15 PM, an interview was conducted with the nursing unit manager. The nursing unit manager stated, Resident dignity is top priority and should be maintained at all times. The unit manager was asked to accompany the surveyor to R3's room. As the surveyor and unit manager were approaching the room, two nursing staff and the dietary manager walk past R3's room to take the meal tray cart to another hallway and did not intervene. Another staff member walked by and entered R3's room to cover the resident. The unit manger walked to the room and confirmed the findings of R3's chest and breasts being exposed. On 6/24/26 during an end of day meeting the above findings were reviewed with the facility Administrator, Director of Nursing, and Regional Director of Clinical Services. No additional information was provided.

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to accurately code an assessment for one resident (Resident #4-R4) in a survey sample of nine residents. The findings included:For R4 the facility inaccurately coded a minimum data set (MDS) assessment to reflect the resident was receiving dialysis treatment. On 6/23/26, the facility provided the surveyor with a CMS-802, Resident Matrix. The document noted that R4 received dialysis treatments. On 6/25/26, during a clinical record review of R4's chart there was no indication in the physician orders, nursing notes, care plan, or documents tab to indicate that the resident was receiving dialysis services/treatments. The admission MDS with an assessment reference date of 5/31/26 was reviewed and section O0110. Special Treatments, Procedures, and Programs noted on question J1 that R4 had received dialysis on admission and while a resident. Question J2 noted that R4 recieved hemodialysis. The Director of Nursing (DON) was asked to confirm if R4 was a dialysis patient. The DON stated she would have to check her list and get back to the surveyor. The DON returned and confirmed that R4 was not a dailysis patient. On 6/25/26, an interview was conducted with the MDS nurse. The MDS nurse confirmed that R4 was not and had never received dialysis treatments. The MDS nurse reviewed R4's MDS assessment and confirmed that it was inaccurately coded and asked if she could correct it. On 6/25/26, the above findings were reviewed with the facility Administrator, Director of Nursing, and Regional Director of Clinical Services. No additional information was provided.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and facility documentation review, the facility staff failed to serve food in a sanitary manner by failure to wear proper hair restraints in the main kitchen, which had the potential to affect residents on two of two units. The findings included:Facility kitchen staff failed to wear proper hair restraints while preparing food to prevent contamination. On 6/24/26 at 12:50 PM, observations were conducted in the main kitchen. Facility staff were actively working the tray line, preparing lunch meals for residents. A Dietary Aide (other employee #1) was observed handling the plates of food and had significant facial hair. Other Employee #1 was wearing a procedure mask that was under his chin and did not cover his beard, moustache, or sideburns. On 6/24/26 at 12:55 PM, the dietary manager (DM) was asked what the expectation was for hair restraints. The Dietary Manager stated that all staff are to wear hair nets and men are to wear beard guards. When asked about the dietary aide, the DM said, [Other Employee #1's name redacted] wears a face mask that covers his hairs. The DM was asked to look at the Dietary Aide and how his mask was being worn. The DM stated this was not acceptable and asked the dietary aide to pull his mask up and wash his hands. The Dietary Aide did comply, but even with the mask over his mouth, his sideburns and beard below his chin was not contained. On 6/24/26, during an end of day meeting the above findings were reviewed with the facility's Administrator and Director of Nursing. The facility policy regarding hair restraints in the kitchen was requested. On 6/25/26, the facility document titled, In-Service: Hairnets & [NAME] Guards was provided. This document read in part, Purpose: To ensure all staff understand the proper use of hair restraints (hairnets, caps, and beard guards) to prevent food contamination and remain compliant with state survey expectations, infection control, and sanitation standards. There will be no exceptions, and the rule must be strictly enforced at all times . Why this matters: Hair is a major contamination risk in food service. Improper hair restraint can lead to: Hair in food, Cross-contamination, infection control citations, failed audits/survey deficiencies, loss of resident trust and satisfaction .No additional information was provided. No additional information was provided.