STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455494	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenview Wellness & Rehabilitation	7625 Glenview Dr North Richland Hills, TX 76180

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours if the alleged violation involved abuse or neglect and resulted in bodily injury, to other officials (including the state Agency) and the administrator of the facility for 1 of 1 resident reviewed for reporting abuse. CNA A failed to notify the ADM and DON about an accident/hazard regarding Resident #1 that happened on 08/27/25. This failure could place residents at risk for abuse and neglect. Findings included:Record Review of Resident #1's face sheet, dated 09/09/25, reflected a [AGE] year-old female with an initial admission date of 03/24/25 and a re-admission date of 09/03/25. Resident #1 had diagnoses of Paraplegia (loss of voluntary movement and sensation in the lower half of the body), Personality Disorder (mental health conditions characterized by long-term patterns of thinking, feeling, and behaving that deviate significantly from societal expectations and cause distress or impairment in various aspects of life), Anxiety (a common mental health condition characterized by excessive and persistent worry, fear, and unease), Post-Traumatic Stress Disorder (a mental health condition that can develop after experiencing or witnessing a traumatic event, such as a natural disaster, violent crime, or serious accident), Paralytic Syndrome (a medical condition characterized by muscle weakness or paralysis), Tobacco Use, Neuromuscular Dysfunction of Bladder (a condition where the nerves and muscles that control bladder function are impaired)Lack of Coordination (the inability to perform smooth, precise, and controlled movements).Record review of Resident #1's Comprehensive Minimum Data Set, dated [DATE], reflected: Section B Hearing, Speech, and Vision reflected that Resident #1 had clear speech and Vision, had the ability to make herself understood and had the ability to understand others. Section C Brief Interview for Mental Status score reflected a score of 15, which indicated the resident's cognition was normal. Record review of Resident #1's Care Plan, dated 09/09/25, reflected the following:'Focus'Resident #1 utilizes a motorized wheelchair to move around in the room/facility. Resident #1 has been evaluated by Therapy in the usage of a power wheelchair.'Goal'Safe use daily of the electric wheelchair by Resident #1. 'Interventions/Tasks'Transfer: The resident is able to transfer self but should use x1 staff for participation in safety.Resident#1 educated on safe use of electric wheelchair, not to allow other residents to hold on to the back on her wheelchair while in operation. In an interview on 09/09/25 at 9:54 AM, Resident #1 stated on 08/27/25 CNA A came in her room pissed off that she had work the 300 hall. Resident #1 stated she was soaked in urine and CNA A changed her diaper, but her bed was soaked in urine. Resident #1 stated she had asked CNA A if she was going to change the bed sheets, and CNA A responded she would change the sheets when Resident #1 got out of bed. Resident #1 stated she told CNA A that she was ready to get out of bed and that's when CNA A started transferring her to the motorized wheelchair. Resident #1 stated CNA A then pushed a button on the motorized wheelchair and the wheelchair ran into the wall and hit Resident #1's foot when the wheelchair hit the wall. Resident #1 stated that her foot was in pain at the time of the incident, but it was no longer in pain at the time of the interview. In an interview on 09/09/25 at 10:44 AM, CNA A stated she was getting Resident #1 ready to go outside for her smoke break. CNA A said she had gotten the motorized wheelchair next to the bed so Resident #1 could transfer from the bed to the wheelchair. CNA A stated that she pressed the joystick on the motorized wheelchair and the wheelchair zoomed off fast and hit the wall and Resident #1's right foot. CNA A told Resident #1 that she was going to get the nurse and Resident #1 stopped CNA A and stated she was fine and not in any pain and that it was not a big deal. CNA A stated that she was unsure why she did not report the incident immediately to a nurse. She stated that she meant to report it to a nurse when the incident happened, but she had forgot to report it because she was doing multiple things at once. She stated the risk of not reporting incident/accidents in a timely manner can prolong care and it is bad to not report. CNA A stated she was inserviced on how to properly use the motorized wheelchair by unlocking the wheelchair from the bottom and pushing it manually next time. In an interview on 09/09/25 at 2:03 PM, the DON stated that the incident happened on 08/27/25. The DON stated she did not find out about the incident until the next day on 08/28/25 when Resident #1 went to the DON and voiced that she was going to make a complaint to the state and that's when Resident #1 told her that her foot was hurting because of the motorized wheelchair hitting her foot and she requested some pain medicine. The DON stated that she immediately assessed Resident #1's foot, and orders were submitted for x-rays on

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure that each resident received adequate supervision for one (Resident #1) of three residents reviewed for supervision and ensured the environment remained free of accidents hazards. The facility failed to ensure CNA A appropriately transferred Resident #1 from the bed to the motorized wheelchair to ensure accidents did not occur. This failure could place residents at risk of being in an unsafe environment and at risk of accidents and injury. Findings included: Record Review of Resident #1's face sheet, dated 09/09/25, reflected a [AGE] year-old female with an initial admission date of 03/24/25 and a re-admission date of 09/03/2025. Resident #1 had diagnoses of Paraplegia (loss of voluntary movement and sensation in the lower half of the body), Personality Disorder (mental health conditions characterized by long-term patterns of thinking, feeling, and behaving that deviate significantly from societal expectations and cause distress or impairment in various aspects of life), Anxiety (a common mental health condition characterized by excessive and persistent worry, fear, and unease), Post-Traumatic Stress Disorder (a mental health condition that can develop after experiencing or witnessing a traumatic event, such as a natural disaster, violent crime, or serious accident), Paralytic Syndrome (a medical condition characterized by muscle weakness or paralysis), Tobacco Use, Neuromuscular Dysfunction of Bladder (a condition where the nerves and muscles that control bladder function are impaired), Lack of Coordination (the inability to perform smooth, precise, and controlled movements).Record review of Resident #1's Comprehensive Minimum Data Set, dated [DATE], reflected: Section B Hearing, Speech, and Vision reflected that Resident #1 had clear speech and Vision, had the ability to make herself understood and had the ability to understand others. Section C Brief Interview for Mental Status score reflected a score of 15, which indicated the resident's cognition was normal. Record review of Resident #1's Care Plan, dated 09/09/25, reflected the following:'Focus'Resident #1 utilizes a motorized wheelchair to move around in the room/facility. Resident #1 has been evaluated by Therapy in the usage of a power wheelchair.'Goal'Safe use daily of the electric wheelchair by Resident #1.'Interventions/Tasks'Transfer: The resident is able to transfer self but should use x1 staff for participation in safety.Resident#1 educated on safe use of electric wheelchair, not to allow other residents to hold on to the back on her wheelchair while in operation. In an interview on 09/09/25 at 9:54 AM, Resident #1 stated on 08/27/25 CNA A came in her room pissed off that she had work the 300 hall. Resident #1 stated she was soaked in urine and CNA A changed her diaper, but her bed was soaked in urine. Resident #1 stated she had asked CNA A if she was going to change the bed sheets, and CNA A responded she would change the sheets when Resident #1 got out of bed. Resident #1 stated she told CNA A that she was ready to get out of bed and that's when CNA A started transferring her to the motorized wheelchair. Resident #1 stated CNA A then pushed a button on the motorized wheelchair and the wheelchair ran into the wall and hit Resident #1's foot when the wheelchair hit the wall. Resident #1 stated that her foot was in pain at the time of the incident, but it was no longer in pain at the time of the interview. In an interview on 09/09/25 at 10:44 AM, CNA A stated she was getting Resident #1 ready to go outside for her smoke break. CNA A said she had gotten the motorized wheelchair next to the bed so Resident #1 could transfer from the bed to the wheelchair. CNA A stated that she pressed the joystick on the motorized wheelchair and the wheelchair zoomed off fast and hit the wall and Resident #1's right foot. CNA A told Resident #1 that she was going to get the nurse and Resident #1 stopped CNA A and stated she was fine and not in any pain and that it was not a big deal. CNA A stated that she was unsure why she did not report the incident immediately to a nurse. She stated that she meant to report it to a nurse when the incident happened, but she had forgotten to report it because she was doing multiple things at once. She stated the risk of not reporting incidents in a timely manner can prolong care and it is bad to not report. CNA A stated she was inserviced on how to properly use the motorized wheelchair by unlocking the wheelchair from the bottom and pushing it manually next time. In an interview on 09/09/25 at 2:03 PM, the DON stated that the incident happened on 08/27/25. The DON stated she did not find out about the incident until the next day on 08/28/25 when Resident #1 went to the DON and voiced that she was going to make a complaint to the state and that's when Resident #1 told her that her foot was hurting because of the motorized wheelchair hitting her foot and she requested some pain medicine. The DON stated that she immediately assessed Resident #1's foot, and orders were submitted for x-rays on 08/29/25. The DON stated x-ray results returned on 08/30 were negative, which indicated no injuries. The DON stated she expects staff to report all incidents to a