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	11/19/2025

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

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	11/19/2025

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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that all alleged violations involving abuse were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse, to the administrator of the facility and to other officials including to the State Survey Agency where state law provides for jurisdiction in long-term care facilities in accordance with State law through established procedures for 2 of 2 residents (Residents #1 and #2), reviewed for abuse, neglect, and exploitation.The facility failed to report an incident of resident to resident abuse between Resident #1 and Resident #2 that occurred on 10/10/2025.This failure could place residents at risk of abuse, neglect and exploitation.Findings included:Resident #1Record review of Resident #1's admission record, dated 10/21/2025, revealed an [AGE] year-old female who admitted to the facility on [DATE] with a primary diagnosis of vascular dementia (a type of dementia caused by reduced blood flow to the brain). Record review of Resident #1's Quarterly MDS, dated [DATE], revealed a BIMS score of 10, indicating moderate cognitive impairment. Record review of Resident #1's care plan initiated 10/10/25, revealed Resident #1 was the receiver of aggression from another resident and sustained injury to the skin as noted in skin injury care plan. Interventions included the following: - Analyze key times, places, circumstances, triggers, and what de-escalates behavior and document.- Assess and address for contributing sensory deficits- Assess and anticipate resident's needs: food, thirst. toileting needs, comfort level, body positioning, pain etc.- Monitor resident frequently. Document observed behavior and attempted interventions in behavior log.- Separate from potential resident to resident incidents. Take to another area away from resident or residents to calm down and keep safe. If needed, [Health Company Name] eval/treat.Record review of Resident #1's nursing notes, dated 10/10/2025 at 6:57 pm, revealed ADON was notified by attending nurse that [Resident #1] was bleeding. She would not tell him how it happened. This nurse went to the unit with nurse to see if she would tell me and she did. She stated that her roommate [Resident #2] hit her with a hairbrush. She held out her left arm, and you can see the marks made up and down her arm from the bristles of the brush. ADON advised to do incident reports and contact RP for both residents. Residents were separated to avoid further conflict.Record review of Resident #1's nursing notes, dated 7:34 pm, revealed ADON called [RP name] to advise of small marks and [family member] was ok with. She states that she knows her [family member's] skin is fragile. Thanked for calling, no other questions or concerns.Record review of Resident #1's nursing notes, dated 10/10/2025 at 11:13 pm, revealed Pt walking down the hallway from her room holding her left forearm. Nurse noticed skin tear to back of right hand and bruise to left forearm. Pt denies pain or discomfort. Record review of Resident #1's nursing notes, dated 10/11/2025 at 6:55 am, revealed bruise remains to left forearm, denied pain.Record review of Resident #1's nursing notes, dated 10/12/2025 at 10:00 pm, revealed Resident continues with fading bruise to left forearm. Refuses to take wrap off. No concerns voiced all day. Will continue with plan of care in place.Record review of Resident #1's nursing notes, dated 10/13/2025 at 9:20 pm, revealed Resident assisted to another room temporary for tonight due to previous roommate separation and room mate noted to attempt to wander into previous room, notified RP of resident having room change for tonight to ensure separation .Record review of Resident #1's nursing notes, dated 10/13/2025 at 11:28 pm, revealed No behaviors noted on shift.Record review of Resident #1's nursing notes, dated 10/13/2025 at 11:33 pm, revealed skin noted injured with bleeding, non-intact. When asked what happened pt states; 'She did it point at the other pt.Record review of Resident #1's nursing notes, dated 10/14/2025 at 7:41 am, revealed bruise on the left forearm is fading, no behavior observed last night.Record review of Resident #1's nursing notes, dated 10/14/2025 at 3:03 pm, revealed, Resident alert/verbal, no s/sx pain or discomfort, area to right forearm appears dry, no discomfort per resident.Record review of Resident #1's nursing notes, dated 10/14/25 at 4:35 pm, revealed, Spoke to [RP name] regarding resident room change to [room number].Record review of Resident #1's nursing notes, dated 10/14/2025 at 4:35 pm, revealed Verbalized understanding also discussed wound care to left forearm. Discussed about the healing and improvement of area and area is has scabbed over no sign or symptoms of infection.Record review of Resident #1's nursing notes, dated 10/15/2025 at 6:08 am, revealed Resident slept in the new room [number] with no behavior noted.Resident #2Record review of Resident #2's admission record, dated 10/22/2025, revealed a [AGE] year-old female who admitted to the facility on [DATE] with a primary diagnosis of unspecified dementia (dementia without a specified type or cause) Record review of Resident

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	11/19/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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	11/19/2025

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 0684 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 observation, interview and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice, and the comprehensive person-centered care plan for 1 of 4 residents (Resident #1) reviewed for quality of care.The facility failed to ensure Resident #1's weekly skin assessment was completed on 10/17/2025. This failure could place residents at risk of not identifying skin breakdown or injuries, and delayed treatment and monitoring. Findings included:Record review of Resident #1's admission record, dated 10/21/2025, revealed an [AGE] year-old female who admitted to the facility on [DATE] with a primary diagnosis of vascular dementia (a type of dementia caused by reduced blood flow to the brain). Record review of Resident #1's Quarterly MDS, dated [DATE], revealed a BIMS score of 10, indicating moderate cognitive impairment. Record review of Resident #1's care plan, dated initiated 10/10/25, revealed Resident #1 was the receiver of aggression from another resident and sustained injury to the skin as noted in skin injury care plan. Interventions included the following: - Analyze key times, places, circumstances, triggers, and what de-escalates behavior and document.- Assess and address for contributing sensory deficits- Assess and anticipate resident's needs: food, thirst. toileting needs, comfort level, body positioning, pain etc.- Monitor resident frequently. Document observed behavior and attempted interventions in behavior log.- Separate from potential resident to resident incidents. Take to another area away from resident or residents to calm down and keep safe. If needed, [Health Company Name] eval/treat. Record review of Resident #1's weekly skin check, dated 10/10/2025 at 11:04 PM, revealed bruise to left forearm / skin tear to back of right hand.Record review of Resident #1's EHR revealed no weekly skin checks completed since 10/10/2025 . Record review of MAR and TAR for October 2025 revealed the following:- Cleanse left arm with normal saline, pat dry, apply TAO, LOTA every day shift for skin treatment for 10 Days -Order Date-10/14/2025 - D/C Date-10/21/2025- Monitor bruise to left forearm until resolved every shift for Infection prevention -Order Date-10/10/2025 - D/C Date-10/21/2025- Monitor skin to right hand until resolved every shift for Infection prevention - Order Date-10/10/2025 Record review of Resident #1's incident report, dated 10/10/2025 at 8:00 PM, completed by LVN B, revealed Incident Description.Pt walking down the hallway from her room holding her left forearm with blood noted on shirt, skin tear to right hand and nonintact skin noted to left forearm. Resident unable to give description. Unwitnessed. Immediate Action Taken.head to toe skin assessment, pain assessments, trauma assessed. Notified MD, RP, separated resident from roommate.Injuries observed at Time of Incident: Injury type Abrasion on left forearm and Bruise right hand (back). Level of Pain: 0.Interview on 10/21/2025 at 3:30 PM, LVN B stated he did a full skin assessment on Resident #1 and an incident report later that night after she had calmed down on 10/10/2025. He stated he did not see any bruises on the upper right arm when he assessed her. LVN B stated he was not aware of any current bruises on Resident #1's upper right arm. When asked who was supposed to do the next skin assessment LVN B did not know. LVN B stated it just pops up in the system and it will prompt you. LVN B did not give a reason why the weekly skin assessment was not completed on 10/17/25. Interview on 10/21/2025 at 3:53 pm, ADON C stated she was not aware of the bruises on Resident #2's right upper arm. She stated LVN B would have been responsible to complete Resident #1's skin assessment on 10/17/2025. Interview on 10/21/2025 at 4:32 pm, the Administrator stated skin assessments should be completed weekly, depending on the resident. She stated the nurse was responsible for completing assessments and the ADON and DON were responsible for monitoring they were completed. She stated the risk to residents if not done was they were left unmonitored, they could have an adverse injury, or reaction. Interview on 10/22/2025 at 9:14 am, the Corporate Nurse stated they did not have a weekly skin assessment policy. She stated skin assessments should be completed weekly and if the resident refused, then documentation of the refusal. Interview on 10/22/2025 at 10:17 am, the DON stated Resident #1's skin assessment should have been completed on 10/17/2025 by LVN B. She stated the risk to residents was missing or preventing skin breakdown and safety. She stated they would need to be aware of the bruise and monitor, make sure it was not getting bigger or not resolved.