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	02/18/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to treat the residents with respect and dignity for 1 (Resident #1) of 3 residents reviewed. 1. The facility failed to place Resident #1's name on the nameplate outside her room. 2. CNA A failed to wear her name tag when she provided care to Resident #1 .This failure placed residents at risk of needs not being met and not having their rights and dignity respected.Findings Included:Record Review of Resident #1's admission Record revealed Resident #1 was a [AGE] year-old female admitted to the facility on [DATE] with a primary diagnosis of Acute and Chronic Respiratory Failure with Hypoxia (a life-threatening, sudden worsening of gas exchange in patients with pre-existing, long-term lung disease) Record Review of Resident#1's Care Plan revision date 03/20/2025 revealed; Focus for Resident #1 is at increased dependence on staff for activities, cognitive stimulation, social interaction r/t previous condition. Interventions included introduce Resident #1 to residents with similar background encourage/facilitate interaction. Focus for Resident #1 communication problem as she is hard of hearing and required longer time to process. Goal; Resident #1 was able to make basic needs known on a daily basis through the review date. Interventions: Encourage resident to continue speaking even if resident was having difficulty. Focus on a word or phrase that makes sense or responds to the feeling resident is trying to express. Record review of Resident #1's Minimum Data Set Nursing Home Quarterly Item Set dated 02/01/2026 revealed; Resident #1 had a BIMS score of 14, which indicated the resident was cognitively intact. Section GG-Functional Abilities (Self-Care); Resident #1 was Dependent -Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or. The assistance of 2 or more helpers is required for the resident to complete the activity. Resident #1 required assistance for Eating, Oral hygiene, Toileting hygiene, Shower/bathe self, Upper body dressing, Lower body dressing, putting on/taking off footwear, and Personal hygiene. Observation on 02/18/2026 at 11:23 AM revealed the nameplate outside Resident #1's room was not present even when there was a resident in that room. The door was closed and when it opened, two staff members, one of them being CNA A, were observed walking out of the room. CNA A walked out of Resident #1's room without a nametag on her uniform. Interview on 02/18/2026 at 11:28 AM with Resident #1 revealed not all the staff wear their name tags or identify themselves when she asks them their names. She stated she wanted to know their names because she would like to know who was providing care. Interview on 02/18/2026 at 1:02 p.m. with ADON B revealed Resident #1 was moved from a room on the isolation hall to current. She stated it was important to have a name on the nameplate, so staff knew whom they were providing care. When the resident moved rooms, her name should be placed on the nameplate. ADON B stated the risk was not identifying the right person. Interview on 02/18/2026 at 1:58 PM with CNA C revealed staff were trained to knock on the resident's door and identify themselves when they enter the room. CNA C stated the risk was if staff were to go into a resident's room and they do not know who the staff was, the staff may (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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	scare the residents. She stated that when a resident's property was moved it was important that the name was placed outside the new room because staff need to know who was in that room for documentation and care purposes. Interview on 02/18/2026 at 2:17 PM with CNA A revealed; she forgot her name tag in her car. She stated it was important to have name tags on to identify themselves to the residents and let them know what care they will be performing. CNA A stated the residents had the right to proper care, the right to dignity and respect and the right to a safe space and safe area. Interview on 02/18/2026 at 2:33 PM with DON revealed the residents had a right to dignity and their room was their home. DON stated staff were to knock and identify themselves before they enter and provide care. The expectation was staff come to work in their uniform which included wearing a name tag. Interview on 02/18/2026 at 2:38 PM with ADMIN revealed residents have a right to safe place and safe care. Staff were expected to provide a homelike environment. ADMIN stated the expectation was to knock and introduce themselves to the resident before they provide care. The expectation was that staff wear their name tag. The risk was that residents may not know which staff member was in their room. Staff were given a name badge as part of their uniform and if they did not have one, they were to go to HR to receive a replacement. Review of Resident Rights policy date revised: 8/2020 revealed; Employees are to treat all residents with kindness,respect, and dignity and honor the exercise of residents' rights. D. Be fully informed and participate in his/her treatment including being fully informed in alanguage that he or she can understand of his/her total health status including his/her medical condition.Review of Dress Code policy titled Dress Code and Personal Appearance not dated revealed; Employees are required to wear a nametag unless the facility has a specific policy stating otherwise (e.g. IDD facilities). This identifies you and prevents unauthorized people from being in the location.