

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455494	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/08/2026
NAME OF PROVIDER OR SUPPLIER Glenview Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative when there is to commence a new form of treatment for 1 of 5 residents (Resident #1) reviewed for resident rights. On 06/29/26, LVN B failed to notify Resident#1's legal representative about a new order for intravenous Vancomycin (glycopeptide antibiotic used to treat severe bacterial infections) to treat leukocytosis (an increase in the number of white blood cells in the bloodstream). This failure placed residents at risk of not making an informed decision about treatment, and risking side effects and allergic reactions. Findings included: Record review of Resident #1's face sheet, dated 07/08/26 reflected, she was a [AGE] year-old female initially admitted on [DATE] and readmitted on [DATE]. Resident#1 was diagnosed with acute kidney failure unspecified (sudden loss of kidney function), calculus of gallbladder with acute cholecystitis(gallstones) without obstruction, altered mental status (a change in a person's mental function) and cognitive communication deficit (A condition where cognitive impairments disrupt a person's ability to communicate effectively, despite. Face sheet reflected the legal representative was the first emergency contact. Record review of Resident #1's undated care plan reflected, dependent on staff for activities, cognitive stimulation, and social interaction. Resident goal reflected: attend/participation activities of choice.[Resident #1] interventions reflected invite [Resident #1] to activities. Record review of Resident #1's MPOA, dated 04/27/26 reflected, she had a legal representative. Record review of Resident#1 order summary reflected, Premixed Tyzavan (Vancomycin) 100MG in 200 ML water. Infuse intravenously at 133ML/HR over 90 minutes once daily for Leukocytosis for 7 days created by LVN B on 06/29/26. Record review of Resident#1 progress notes reflected no notation of family being contacted on 06/29/26. Late entry written by DON on 06/29/26 reflected: Vancomycin Intravenous Solution Reconstituted 1 GM (Vancomycin HCl). Use 1 gram intravenously one time a day for Leukocytosis for 7 day Record review of an in-service training record, dated 06/20/26, reflected that nursing staff were trained on resident right, customer service, medication administration (pain), abuse, neglect and exploitation. During an interview on 07/08/26 at 9:45 a.m., Resident #1's Family Member #1 stated when he visited Resident#1 at the facility, she was getting a IV line put in for antibiotics. Family Member #1 stated he was not notified, and he checked with Resident#1's legal representative, who also had not been notified either of the treatment. During an interview on 07/08/26 at 10:15 a.m., Resident #1's Legal Representative stated he was not notified of Resident#1's new treatment. During an interview on 07/08/26 at 12:20 p.m., the ADON stated Family Member #1 wanted to send Resident #1 to the hospital because she looked pale, and he wanted the hospital to do the PICC instead of the third party at the facility. The ADON stated she educated Family Member #1, and he decided to send (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 to the hospital. The ADON stated the family should have been notified as soon as the order was received. During an interview on 07/08/26 at 12:50 p.m., the DON stated the family should have been notified when a new order came in from the NP, so the family knew what was going on and could say yes or no to treatment. The DON stated it was important to contact and educate the residents' families. During an interview on 07/08/26 at 1:54 p.m., over the phone, the NP stated on Sunday (06/29/26) evening, she called in the order for IV antibiotics for leukocytosis. During an interview on 07/08/26 at 2:08 p.m., RN A stated she received shift report from LVN B about Resident #1's order for IV antibiotics. RN A stated she was told by LVN B that family had been notified. An attempt was made to interview RN C on 07/08/26 at 2:16 p.m. via telephone; however, there was no answer. During an interview on 07/08/26 at 2:19 p.m., the Administrator stated that the family should be notified of any change in the resident and treatment. The Administrator stated families were at risk of not knowing what was provided to resident for their care. During an interview on 07/08/26 at 2:20 p.m., the DON stated the nurse, who put in the order, was responsible for notifying the family. The DON stated she was responsible for in-service with nursing staff. The DON stated families were at risk of not assisting and being aware of treatment and care provided to the residents. On 07/08/26 at 2:34 p.m., an interview was attempted with LVN B via telephone. Although she answered, she stated she could not talk and would call back; however, she did not call back. Record review of the facility's Change of Condition Notification policy reflected: to ensure residents, family legal representatives, and physicians are informed of changes in the residents condition in a timely manner.policy.C. A significant change in treatment.		