STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455835	A. Building B. Wing	03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Interlochen Health and Rehabilitation Center	2645 West Randol Mill Rd Arlington, TX 76012

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 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44970 Based on observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that include measurable objectives and time frames to meet residents' mental and psychosocial needs for 1 of 3 (Residents #1) Residents reviewed for care plans. The facility failed to ensure Resident #1's CNA-J followed care plan interventions for proper supervision and incontinence care. This failure could place resident #1 at risk for injuries. Findings included: Record review of Resident #1's face sheet dated 3/20/24 reflected an [AGE] year-old female admitted on [DATE]. DX: age related cognitive decline, history of falling, other lack of coordination. Record review of Resident #1's quarterly MDS dated [DATE] reflected a BIMS score of 00. Resident dependent on staff for all activities including eating, oral hygiene, personal hygiene, showers, and bath. Section V listed no falls during the lookback period. Record review of Resident #1's Care plan dated 01/06/24 with related fall on 03/17/24 reflected Resident had was at risk of falls, r/t impaired mobility, impaired coordination, and impaired cognition, weakness, and disease process anticipate needs, call light in reach, educate, and remind staff about safe environment. Dependent on staff to meet needs .Ensure/provide a safe environment: Call light in reach, Adequate low glare light, Bed in lowest position and wheels locked, impaired vision, bladder and bowel incontinence d/t cognitive impairment, mobility, history of right fibula (calf bone) fracture, pain, dementia, history of falls .care plan for mobility, ADLS, cognitive, and communication. Record review of Resident #1's MD orders dated 03/18/24 reflected Remove sixteen staples in two weeks apply steri-strips one time a day .cleanse sixteen staples to forehead with and pat dry. Apply ointment and may leave open to air until resolved one time a day and one time only until 03/18/24. Tylenol Extra Strength Oral Tablet 500 MG (Acetaminophen). Give one tablet by mouth two times a day for pain. Requires extensive assistance from staff for toileting, requires mechanical lift X2 staff assistance to transfer. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #1's MD order to admit to hospice dated 01/05/24 prior to lab draws, x-rays, other consults. No directions specified for order. Record review of Resident #1's fall note dated at 1:27 PM by LVN R reflected falling resident room, hit head, fall from low bed, cognitive impairment, oriented to person, place and time, obeys commands, pupils equal, injury yes, head, bleeding, resident verbal, pain Tylenol 325 mg, don't know what happened hospice was notified on 03/17/24 at 12:41 PM intervention low bed. Record review of Resident #1's fall assessment dated [DATE] reflected low-risk for falls, four by LVN E. Record review of Resident #1's fall assessment dated [DATE] at 9:08 PM by LVN R reflected resident fall risk was low. Record review of Resident #1's PN dated 03/20/24 at 08:30 PM by LVN K Text: 03/18/24 Bolster Mattress requested from '[company name]'. Rep, '{company]' stated it will be delivered as soon as possible. follow up call on 03/20/24 about the bolster Mattress'{company]' stated that it's been ordered and will be delivered soon. Record review of Resident #1's PN dated 03/17/24 at 12:30 PM by LVN R reflected Progress Note Late Entry: Note Text: This writer was notified by the caregiver that resident slide from bed and fall on the floor facing the window side, this nurse immediately went to room and observed PT on the floor lying on the left side, Head to toe assessment done and resident was noted with laceration on the middle of the head measuring 10 cm X 1 cm, this nurse by the help of the caregiver stopped the bleeding and assisted the pt. from the floor assessed her vitals resident was noted with no skin issue' at the time, this writer call 911, notified DON, Family member MD notified, Hospices notified, safety precautions in place bed in the lowest position, floor mat in place call light within reach. Record review of Resident #1's PN dated 03/17/24 time 2:21 PM by LVN-R reflected This nurse was notified by the caregiver that resident slid down from bed to floor and hurt his head and was bleeding from the head and this nurse did first aid and stopped the bleeding, this nurse received an order to send resident to hospital for further evaluation. This nurse notified the DON, family member and message left on voice mail. Record review of Resident #1's PN dated 03/17/24 at 9:05 PM by LVN-R reflected Resident returned from hospital on stretcher by EMS at around 8:45 PM, she was safely transferred to bed by two persons. resident come with sixteen staples on her head which can be removed .this nurse notified the [name] Hospice about the return from hospital, Family member notified Administration notified. DON safety precautions in place, Bed in the lowest position, up 30 to 45 degrees, floormat in place call light within resident reach. Record review of Resident #1's PN dated 03/18/24 at 12:59 PM reflected Progress Note: resting in bed quietly, staples are intact with no bleeding or drainage noted, remains on ABT with NAR .skin warm to touch, turgor (elasticity) is good. accepted fluids and meals well. does not make basic needs known, all needs met by staff. call into hospice pending regarding routine pain meds. (continued on next page)

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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 0656 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #1's Change of condition completed on 03/17/24 at 2:03 PM reflected functional status change hypothyroidism Dementia Sent pt to Hospital notified. Record review of Resident #1's Kardex (Kardex is a documentation system that helps nurses organize and access key patient for their care plan.) dated 03/20/24 reflected Educate and remind staff about safe environment Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface .Monitoring In absence of b/p, pulse, respiration. Record review of Resident #1's provider investigation dated 03/18/24 reflected Pertinent Medical Diagnosis: History of falling, Lack of coordination, Cognitive communication deficit .Level of cognition: BIMs 99 indicating she was severely impaired cognitively and was not interviewable.Incident Details to ED Date: 3/18/24 at 9:00 AM Date/Time the incident occurred: 03/17/24 at 2:20 PM. Record Review of Provider Investigation Reported dated 03/19/24 reflected Resident '[Resident#1]' slid out of the bed during incontinent care Witnesses '[CNA-J]' .Assessment The date and time of the assessment: 03/17/24 at 2:20 PM completed by '[LVN-R]' Resident #1 was observed with bleeding from a laceration on the head. LVN-R stated Resident #1 was sent to hospital emergency room for evaluation of injuries . Resident #1 was given sixteen staples. RP, MD & DON were notified. CNA was given counsel and provided 1:1 education on safety awareness while providing incontinent care. Licensed and certified staff were provided education on safety awareness while providing incontinent care. Record review of CNA-J's individual coaching by DON on 03/18/24 reflected on 03/17/24 the following deficient were found, resident safety .this is a reminder of expectations lower resident beds for safety, whenever you back are facing resident .never leave bed elevated if you must turn your back on the resident. Record review of CNA-J's statement dated 03/18/24 reflected I was providing care for the resident, and I had to get her brief off nightstand .I did not lower the bed. As I turned around with my back facing the resident, I heard a loud noise .when I turned back, she had fallen out of the bed hitting her head on the floor, I called nurse who entered room and provided first aid to resident. Record review of in-service dated 03/01/8/24 by DON reflected Fall interventions are found on the resident in Kardex, POC, and task in electronic records documentation attached. In an interview with the ADON on 03/20/24 at 2:20 PM the ADON staff should enter the rooms for incontinent care together, to prevent accidents. ADON said the risk of not providing two staff could result in injuries of the resident falling off the bed. ADON expects both staff to be present, and the ADON, DON, and nurses will continue to monitor and train staff on safe practices. In an interview on 03/20/24 at 2:30 PM with CRN she revealed Resident #1's initial care plan stated Resident #1 required one person for incontinent care. CRN stated this was determined after a fall assessment score of 4 (indicating low-risk). CRN stated Resident #1 was assessed at the hospital by CT scan to assess possible injuries and fractures. The CT scan was negative for fractures. CRN stated the hospital staff performed an UA, and she was prescribed antibiotics for an UTI. CRN stated that the clinical staff (the IDT) reviewed and modified Resident #1's incontinent care task, and interventions for safety. New interventions for Resident #1 include having two staff must be present and positioned on each side of the bed for incontinent care. (continued on next page)

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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 0656 Level of Harm - Actual harm Residents Affected - Few	In an interview on 03/20/24 at 3:04 PM with ADM revealed the expectations of staff were to provide care consistent with resident needs and care plans. ADM stated that CNA-J failed to request additional staff during incontinent while providing care. He stated that the risk of staff failing to follow care plans could result in serious injuries, hospitalization s, and decline in resident level of care. Record review of facility policy dated 10/05/16 titled preventative strategies to prevent fall risk. The goal of fall prevention strategies is to design interventions that maximize fall risk by eliminating or managing contributing factors while keeping or improving the resident's mobility. Procedure: After risk is assessed, individualized nursing care plans will be implemented to prevent falls. The resident and family members will be educated on methods to prevent falls. Interventions will focus on manipulating the environment, educating the resident/family, implementing rehabilitation programs to improve functional ability, and care monitoring of medication side effects. Medical Strategies: a) Identify residents at risk for falls, b) Identify sign/symptom of underlying disease or medication effect that requires a clinician's attention in order to rule out reversible acute problems, c) Identify chronic medical conditions that may contribute to fall risk and treat appropriately, d) Assess medications, e) Provide PT/OT evaluation and treatment as needed. Rehabilitation Strategies: a) low intensity leg strengthening and weight bearing exercise, b) gait, balance, and transfer training. The policy for care plan was not requested; therefore, it is not listed for record review.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44970 Based on observation, interviews, and record review, the facility failed to ensure resident environment remained as free of accidents hazards as possible: and each resident recieved adequate supervision and assistance devices to prevent accidents for 1 of 3 residents (Resident #1) reviewed for accidents and hazards. The facility failed to ensure Resident #1's CNA-J followed care plan interventions for proper supervision and incontinence care. This failure could place resident #1 at risk for injuries. Findings included: Record review of Resident #1's face sheet dated 3/20/24 reflected an [AGE] year-old female admitted on [DATE]. DX: age related cognitive decline, history of falling, other lack of coordination. Record review of Resident #1's quarterly MDS dated [DATE] reflected a BIMS score of 00. Resident dependent on staff for all activities including eating, oral hygiene, personal hygiene, showers, and bath. Section V listed no falls during the lookback period. Record review of Resident #1's Care plan dated 01/06/24 with related fall on 03/17/24 reflected Resident had was at risk of falls, r/t impaired mobility, impaired coordination, and impaired cognition, weakness, and disease process anticipate needs, call light in reach, educate, and remind staff about safe environment. Dependent on staff to meet needs .Ensure/provide a safe environment: Call light in reach, Adequate low glare light, Bed in lowest position and wheels locked, impaired vision, bladder and bowel incontinence d/t cognitive impairment, mobility, history of right fibula (calf bone) fracture, pain, dementia, history of falls .care plan for mobility, ADLS, cognitive, and communication. Record review of Resident #1's MD orders dated 03/18/24 reflected Remove sixteen staples in two weeks apply steri-strips one time a day .cleanse sixteen staples to forehead with and pat dry. Apply ointment and may leave open to air until resolved one time a day and one time only until 03/18/24. Tylenol Extra Strength Oral Tablet 500 MG (Acetaminophen). Give one tablet by mouth two times a day for pain. Requires extensive assistance from staff for toileting, requires mechanical lift X2 staff assistance to transfer. Record review of Resident #1's MD order to admit to hospice dated 01/05/24 prior to lab draws, x-rays, other consults. No directions specified for order. Record review of Resident #1's fall note dated at 1:27 PM by LVN R reflected falling resident room, hit head, fall from low bed, cognitive impairment, oriented to person, place and time, obeys commands, pupils equal, injury yes, head, bleeding, resident verbal, pain Tylenol 325 mg, don't know what happened hospice was notified on 03/17/24 at 12:41 PM intervention low bed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #1's fall assessment dated [DATE] reflected low-risk for falls, four by LVN E. Record review of Resident #1's fall assessment dated [DATE] at 9:08 PM by LVN R reflected resident fall risk was low. Record review of Resident #1's PN dated 03/20/24 at 08:30 PM by LVN K Text: 03/18/24 Bolster Mattress requested from '[company name]'. Rep, '{company]' stated it will be delivered as soon as possible. follow up call on 03/20/24 about the bolster Mattress'{company]' stated that it's been ordered and will be delivered soon. Record review of Resident #1's PN dated 03/17/24 at 12:30 PM by LVN R reflected Progress Note Late Entry: Note Text: This writer was notified by the caregiver that resident slide from bed and fall on the floor facing the window side, this nurse immediately went to room and observed PT on the floor lying on the left side, Head to toe assessment done and resident was noted with laceration on the middle of the head measuring 10 cm X 1 cm, this nurse by the help of the caregiver stopped the bleeding and assisted the pt. from the floor assessed her vitals resident was noted with no skin issue' at the time, this writer call 911, notified DON, Family member MD notified, Hospices notified, safety precautions in place bed in the lowest position, floor mat in place call light within reach. Record review of Resident #1's PN dated 03/17/24 time 2:21 PM by LVN-R reflected This nurse was notified by the caregiver that resident slid down from bed to floor and hurt his head and was bleeding from the head and this nurse did first aid and stopped the bleeding, this nurse received an order to send resident to hospital for further evaluation. This nurse notified the DON, family member and message left on voice mail. Record review of Resident #1's PN dated 03/17/24 at 9:05 PM by LVN-R reflected Resident returned from hospital on stretcher by EMS at around 8:45 PM, she was safely transferred to bed by two persons. resident come with sixteen staples on her head which can be removed .this nurse notified the [name] Hospice about the return from hospital, Family member notified Administration notified. DON safety precautions in place, Bed in the lowest position, up 30 to 45 degrees, floormat in place call light within resident reach. Record review of Resident #1's PN dated 03/18/24 at 12:59 PM reflected Progress Note: resting in bed quietly, staples are intact with no bleeding or drainage noted, remains on ABT with NAR .skin warm to touch, turgor (elasticity) is good. accepted fluids and meals well. does not make basic needs known, all needs met by staff. call into hospice pending regarding routine pain meds. Record review of Resident #1's Change of condition completed on 03/17/24 at 2:03 PM reflected functional status change hypothyroidism Dementia Sent pt to Hospital notified. Record review of Resident #1's Kardex (Kardex is a documentation system that helps nurses organize and access key patient for their care plan.) dated 03/20/24 reflected Educate and remind staff about safe environment Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface .Monitoring In absence of b/p, pulse, respiration. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of facility policy dated 10/05/16 titled preventative strategies to prevent fall risk. The goal of fall prevention strategies is to design interventions that maximize fall risk by eliminating or managing contributing factors while keeping or improving the resident's mobility. Procedure: After risk is assessed, individualized nursing care plans will be implemented to prevent falls. The resident and family members will be educated on methods to prevent falls. Interventions will focus on manipulating the environment, educating the resident/family, implementing rehabilitation programs to improve functional ability, and care monitoring of medication side effects. Medical Strategies: a) Identify residents at risk for falls, b) Identify sign/symptom of underlying disease or medication effect that requires a clinician's attention in order to rule out reversible acute problems, c) Identify chronic medical conditions that may contribute to fall risk and treat appropriately, d) Assess medications, e) Provide PT/OT evaluation and treatment as needed. Rehabilitation Strategies: a) low intensity leg strengthening and weight bearing exercise, b) gait, balance, and transfer training. The policy for care plan was not requested; therefore, it is not listed for record review.