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	06/07/2024

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 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** 48520 Based on observation, interview and record review the facility failed to treat each resident with respect, dignity, and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for two (Resident #2 and Resident #3) of seven residents reviewed for dignity. The facility failed to ensure Resident #2 was provided with a dignified dining experience, when CNA D stood over her as she was assisting Resident #2 in eating a lunch meal service in the dining room. The facility failed to ensure Resident #3 was provided with a dignified dining experience, when a medical records staff stood over her as she was assisting Resident #3 in eating a lunch meal service in the dining room. This failure could place residents at risk for a loss of dignity, decreased self-worth, and decreased self-esteem. Finding included: Resident #2 Review of Resident #2's face sheet dated 06/07/24 reflected a [AGE] year old female admitted to the facility on [DATE]. Her diagnoses included age related cognitive decline, history of falling, lack of coordination, macular degenerative is an eye disease that causes vision loss, dementia is s cognitive decline of long term and short-term memory. Record review of Resident #2's quarterly MDS dated [DATE] reflected a BIMS of 0. Indicating severe cognitive impaired. Functional ability reflected that Resident #2 was dependent on staff to do all the effort to eat, oral care, toileting, shower/bath, dressing, and personal hygiene. Review of Resident #2's orders dated 06/07/24 reflected a regular diet, regular texture, regular consistency diet. Resident #3 (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	Review of Resident #3 face sheet dated 06/07/24 reflected a [AGE] year old female admitted to the facility on [DATE]. Her diagnoses included muscle dying and wasting, stroke, cognitive communication difficulty, dysphagia and pharyngeal phase a condition of difficulty with the swallowing reflex and squeezing food down into the larynx [throat]. Record review of Resident #3's quarterly MDS dated [DATE] reflected a BIMS of 0. Indicating severe cognitive impaired. Her functional ability indicated Resident #3 required supervision or touching assistance while eating. The helper would provide verbal cues and or touching guard assistance as resident complete task. Assistance may be provided throughout the activity or intermittently. Record review of Resident #3's care plan on 06/07/24 reflected that Resident #3 had a unplanned/unexpected weight loss due to impaired cognition initiated 03/05/24. The goal was to Stabilize Resident #3's week within 4 weeks with a target date 04/29/24. Interventions included giving Resident #3 supplements, monitoring, and recording food intake at each meal, notifying dietitian, physician, and family of further weight loss, placing a red glass on the resident's tray to alert staff as resident needing assistance/encouragement and substitutes to encourage meal intake. Observation and interview in dining room on 06/07/24 at 12:36 PM, revealed Resident #2 and Resident #3 on the same table in their geri chairs. Resident #3 crying out help me, help me up while Resident #3 was holding a bread roll in her hand. Both residents had their food trays in front of them. CNA D came to the table and stood in front of Resident #3 and started to feed her. Moments later a personnel staff member came to the table stood in front of Resident #2, she took the fork with the 3 fries on it and tried to feed Resident #2 while standing over her. An interview with CNA D on 06/07/24 at 12:48 PM, she said that she should have sat down so that she could be at eye level with the resident and watched her to make sure she did not choke on her food. She said that she only gave Resident #3 a few scoops of fish before another CNA came and told her that Resident #3 did not need assistance eating so she stopped. She said sitting down while assisting a resident eat promoted dignity. An interview with personnel staff on 06/07/24 at 1:00 PM, she said sitting down while assisting a resident eat promoted dignity and she could be at eye level to make sure that Resident #2 could swallow properly. She stated that she would not like someone to stand over her while she ate. In an interview on 06/07/24 at 6:43 PM, the DON stated staff should be sitting next to residents when assisting them to eat. She said this respected their dignity by promoting a respectful environment. She said staff needed to be mindful of resident's dignity. She said staff were in serviced on resident rights and dignity. Interview with Administrator on 06/07/24 at 7:15 PM, revealed he expected all staff to follow facility policy and to provide all residents dignified dining experience. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy titled, Resident Rights, undated, reflected, All residents have a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility including those specified in this policy. The Facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment, that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The Facility will protect and promote the rights of the resident and provide equal access to quality of care regardless of diagnosis, severity of condition, or payment source. Record review of facility in service dated 05/20/24 titled , Residents Rights, Privacy and Dignity, reflected, To ensure that care and services provided by the Facility promote and/or enhance privacy, dignity, and overall quality of life . V. The Facility promotes independence and dignity in dining .

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F 0656 Level of Harm - Minimal harm or potential for 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** 48520 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 the resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment and the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 7 residents (Resident #1) reviewed for care plans. The facility failed to develop an individualized comprehensive care plan that addressed how Resident #1's was to be physically transferred. This deficient practice could place residents at risk of receiving inadequate interventions that were not individualized to their care needs and at risk for injuries. Findings included: Review of Resident #1 face sheet dated 06/07/24 reflected a [AGE] year-old male that was admitted to the facility on [DATE]. His diagnoses included cerebral palsy a congenital disorder of movement, muscle tone and posture, scoliosis is a sideway curvature of the spine (cannot walk or sit upright), muscle weakness, limitation to activity due to disability, and protein calorie malnutrition. Record review of Resident #1's quarterly MDS dated [DATE] reflected BIMS score of 12 indicating moderately impaired cognition. Resident could be understood, and he could understand others. He used a custom electric wheelchair to ambulate. Functional abilities status indicated he required partial/moderate assist in eating. He was dependent on staff to do all the effort for bed mobility, transfer, toileting, and personal hygiene. Record review of Resident #1's care plan dated 05/29/24 reflected Resident #1 had ADL self-care performance deficit. The goal was for Resident #1 to maintain or improve his current level of function in bed mobility, transfer, eating, dressing, toilet use and personal hygiene. Interventions included the following: Transfer- Resident #1 required total assist X2 staff participation with transfer. Bed mobility- Resident #1 required extensive assist X 2 staff participation to reposition and turn in bed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview with Resident #1, CNA A, and LVN C on 06/07/24 at 11:47 AM, revealed Resident #1 in a shower bed lying on his left side. CNA A was alone as she pushed shower bed from shower room to Resident #1's room. Resident #1 was observed not having a mechanical lift sling underneath him. Resident #1 said that since his admission to facility (02/21/24), facility staff had not used a mechanical lift on him. He said that the staff usually would have one person holding his shoulders and another would grab his legs to transfer from bed to chair or vice versa. Resident #1 said that he was used to being transferred by someone picking him up because he had three brothers and they usually picked him up in their arm's cradle position. Resident #1 said that he could not sit, walk, or stand due to his comorbidity. Resident #1 said that it did not hurt him when he was transferred by facility staff using his body to lift. He said that he had a custom-made wheelchair that he would like to get into after getting dressed. CNA A said that LVN B assisted her to transfer Resident #1 from his bed to the shower bed and she demonstrated how they transferred Resident #1 by motion movement of one person grabbed his shoulders and another person grabbed his legs. CNA A then called LVN C into room to assist her move Resident #1 to his bed from shower bed. LVN C asked CNA A to go and get a mechanical lift and a sling. Interview with LVN C on 06/07/24 at 3:36 PM, revealed she had been employed at the facility for two to three months. She said that she had never transferred Resident #1 until that day (6/7/24). She said that she had not observed any of the staff transfer Resident #1 using his body. She said that it sounded like Resident #1 preferred to be lifted by his body. She said the risk to the resident was that it was unsafe to be transferred this way especially if he was wet, he could be dropped. Interview with CNA A on 06/07/24 at 1:19 PM, revealed she had been employed at the facility for one month. She said that when she was shadowing another CNA during training, that (the body lift) was what she observed the other CNAs do when transferring Resident #1. CNA A said that she was only doing what she found everyone else doing in the facility. She said that she knew that she was not strong enough to lift Resident #1 by the shoulders so she usually held his feet/leg portion of his body and someone else stronger than her would lift him off by the shoulders. CNA A said that she had been trained on how to use a mechanical lift. CNA A did not state the risk for transferring Resident #1 using his body to lift him. Interview with Physical Therapist on 06/07/24 at 03:58 pm, revealed if a resident was dependent on staff to do all the lifting and could not sit on side of bed or stand, then a mechanical lift was a recommended transfer method. She said that she had not assessed Resident #1 and was unaware of his mobility level. She said that if a resident was dependent on mobility, then it should be care planned for the resident to have 2 persons assist and a mechanical lift to transfer. She said that she could not state the risk because she did not know Resident #1's mobility. Interview with DON on 06/07/24 at 6:43 PM, revealed nursing staff should not have been moving Resident #1 using his body to lift. She said after finding out about the incident on that day (6/7/24), she talked to Resident #1, and he said that the staff used a sheet to transfer him. She said that the risk to any resident being transferred using their body to lift was that it was unsafe, and they could fall, or a fracture can occur during body handling. She said that if a resident was a total dependent resident, then nursing staff needed to use a mechanical lift to transfer. She said that it was the DON, MDS nurse, and ADON's responsibility to make sure that care plans were updated. She said she was going to audit all care plans for residents with two persons assist. She said that she would review Resident #1's care plan and include a mechanical lift for transfer. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Administrator on 06/07/24 at 7:15 PM, revealed he expected all staff to follow facility policy. Review of the facility's policy titled, Comprehensive Care Planning 03/18, reflected, The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment; .The comprehensive care plan will reflect interventions to enable each resident to meet his/her objectives. Interventions are the specific care and services that will be implemented.