

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455835	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2025
NAME OF PROVIDER OR SUPPLIER Interlochen Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51047</p> <p>Based on observation, interview, and record review, the facility failed to ensure based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 (Resident #1) of 4 residents reviewed for quality of care.</p> <p>LVN A failed to read an abnormal x-ray result, resulting in Resident #1 experiencing pain with a hip fracture for 2 days before Resident #1 was hospitalized for evaluation.</p> <p>A past noncompliance Immediate Jeopardy was determined to have existed from 4/8/2025 to 4/10/2025. While the IJ was removed on 4/11/2025, the facility remained out of compliance at a scope of isolated and a severity of no actual harm with the potential for more than minimal harm to resident health or safety due to the facility's need to implement corrective systems. The facility implemented actions that corrected the IJ on 4/11/2025 before the surveyor's entry.</p> <p>This failure could place residents at risk of delayed medical evaluation, treatment, and decrease in quality of care.</p> <p>Findings included:</p> <p>Review of Resident #1's face sheet, dated 4/23/2025, revealed resident was a [AGE] year-old female admitted on [DATE] with diagnoses of muscle weakness, dementia, and hypertension.</p> <p>Review of Resident #1's MDS assessment, dated 2/17/2025, revealed that resident's BIMS score was 4 out of 15 , indicating Resident #1 has low cognitive function.</p> <p>Review of Resident #1's Fall risk assessment, dated 4/5/2025, revealed that Resident #1 had balance problems while walking, decreased muscular coordination, and required use of assistive devices.</p> <p>Review of Resident #1's nursing note, dated 4/5/2025 at 9pm, LVN I documented that Resident #1 on 4/5/2025 during dinner time stood on the door way calling and asking if someone could help her .[Resident #1] said that she fell and was hurting on her left side of the torso. When she was asked how she fell and what she was doing at the time, the resident doesn't know and doesn't remember how it happened. Head to toe assessment was done. LVN I also indicated in this note that NP was notified and X-ray orders were obtained. Order for Tylenol extra strength 500mg tablets by mouth was also placed.</p> <p>(continued on next page)</p>

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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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of Resident #1's nursing note, dated 4/6/2025 at 8pm, LVN I reported and faxed negative X-ray result to NP.</p> <p>Review of Resident #1's nursing note, dated 4/8/2025 at 1:54pm, LVN B performed pain assessment which showed Resident #1 was in pain on her left hip and left waist. LVN B notified NP at 10:17am, LVN B notified Resident #1's family member at 11:16am, stat X-ray was ordered.</p> <p>Review of nursing note, dated 4/8/2025 at 10:24pm, LVN A stated X-ray result faxed to NP for review no new orders.</p> <p>Review of Resident #1's nursing note, dated 4/10/2025 at 10:18am, LVN B noted [Resident #1] complains of pain to left side of body . Routine pain managements appear to be not effective as resident continues to complain of increased pain . Resident appears to be dragging left leg when attempting to make a step. All previous X-ray results to bilateral hips and waists and chest X-ray were negative. LVN B also noted that NP was consulted, EMS was called, and Resident #1's grandson was notified.</p> <p>Review of hospital record, dated 4/10/2025, revealed that x-ray done on 4/10/2025 at the hospital showed fracture to the left hip. Treatment in the hospital included pain management with Tylenol and Robaxin.</p> <p>Review of Resident #1's bilateral hips X-ray result, dated 4/8/2025, revealed that the impression of her left hip X-ray was stable acute appearing nondisplaced fracture noted of the superior and inferior of the left pubic rami (left pelvic fracture).</p> <p>In an observation and interview on 4/23/2025 at 12:30pm, Resident #1 was sitting in her wheelchair in the dining room. Resident #1 stated that she did not remember why she fell , but she remembered having a fracture. She stated that she was still having some discomfort from the fall, especially when she had to shift herself in the wheelchair. She stated that the pain had been interfering with her activities of daily living but she stated that pain was improving.</p> <p>In an interview on 4/23/2025 at 12:15pm, LVN B stated that on 4/8/2025, LVN B consulted the NP to order a stat X-ray because Resident #1 was still complaining of pain. When she left her shift on 4/8/2025, the result had not come back, so she relayed the message to LVN A to look out for the result. LVN A read the result on the evening of 4/8/2025, and reported to LVN B on morning of 4/9/2025 as negative via verbal reporting. LVN B did not look at the report and only took LVN A's verbal report. LVN B stated that when Resident #1 was sent to the hospital on 4/10/2025, she retrieved the X-ray report on 4/8/2025 from Resident #1's chart and realized that LVN A has misread the result.</p> <p>In an interview on 4/23/2025 at 1pm, the NP stated that she could not remember exactly what happened, but she remembered Resident #1 had 2 negative X-rays. She stated the fax of the second X-ray result on 4/8/2025, never got to her so LVN A called her to read the X-ray result verbally.</p> <p>On 4/23/2025 at 2:45pm, an attempt to interview LVN A via phone was unsuccessful.</p> <p>An Immediate Jeopardy (IJ) was determined to have existed from 4/8/2025 to 4/10/2025. The facility Administrator was provided the Immediate Jeopardy Template on 4/23/2025 at 3:39pm.</p> <p>Review of the facility's Provider Investigation Report, dated 04/11/25, revealed:</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The charge nurse will notify NP/MD of any changes of condition noted in a resident. If there is no response from either, the charge nurse will call again and if no answer they will send the resident to the ER .</p> <p>. Any fractures must be reported to DON/ADON as soon as the charge nurse becomes aware of them. Along with faxing X-ray results you must call the NP/MD and document notification.</p> <p>. Failure to review X-ray findings timely could delay care and be considered neglect.</p> <p>.ADON/DON will have all labs and X-ray results in the morning meeting to review daily.</p> <p>Labs and X-ray reports must be reviewed upon receipt. This involves reading the whole lab or x-ray report first page to however many pages follow. Once the report is read and there are abnormal findings the physician or NP must be called; this is not an option. After notifying them of the report the nurse is to document MD notification of x-ray report .</p> <p>In an interview on 4/23/2025 at 3:40pm, LVN C, who was a night shift nurse, stated that when he received an x-ray result, he would fax it to NP/MD, then call them to report the result, read every single page on the report, and report to ADON/DON. He stated that the risk of not reading the x-ray result correctly put the residents at risk for more pain and incorrect care. He was in-serviced about reading x-ray results and reporting to NP/MD 2 weeks ago.</p> <p>In an interview on 4/23/2025 at 3:48pm, LVN D, who was a day shift nurse, stated that the process of reporting x-ray result to NP/MD included: receiving the result, reviewing the result by reading all pages, calling NP/MD to report, and faxing the result to NP/MD, reporting to ADON/DON if any results came back abnormal. She stated the risk of reading incorrect results could lead to residents having increased pain, and risk of infection. She stated she was in-serviced a few weeks ago.</p> <p>In an interview on 4/23/2025 at 3:58pm, RN E who was a wound nurse, stated that she had not had to call NP/MD to report an imaging result. She stated she was in-serviced a couple of weeks ago. She stated that the process of report any abnormal labs or imaging results included: receiving the results, if abnormal, notify ADON/DON and NP immediately, read the result every single page, call NP/MD, fax the reports to NP/MD. She also stated that ADON/DON and Administrator met with all nurses to talk about the incident on 4/8/2025. She stated that the in-service included training all nurses to read all pages of reports and fax reports to the correct numbers.</p> <p>In an interview on 4/23/2025 at 4:17pm, LVN F, who usually worked weekend shifts, stated that once he received an anormal lab or abnormal imaging result, he reported to NP/MD and ADON/DON immediately. He also stated that ADON/DON also started going over 24-hour reports with all nurses every morning to look at any abnormal lab results or imaging findings.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>In an interview on 4/24/2025 at 11:30am, the DON stated that when Resident #1 was sent to the hospital on 4/10/2025, the DON, regional nurse, and all nurses reviewed Resident #1's clinical records to see what they missed and why the Resident #1 continued to have pain. DON stated they realized after looking at the X-ray on 4/8/2025 they had missed the fracture result. LVN A was in-serviced immediately. DON stated that LVN A told her she only saw 1 page of the report and that page stated no fracture, so she reported a negative result to the NP. The DON stated that all nurses were in-serviced immediately. The new process included: all nurses to let the DON know of any abnormal lab or imaging results, and report to NP/MD. ADON and DON would go over each resident's 24-hour report during every morning meeting to review all labs and imaging results. DON also stated that she printed out a sticker listing correct fax numbers for NP and MD at all nurse stations. DON stated that she expected nurses to do their own auditing after they report results to NP/MD and during morning meeting ADON/DON would do second layer of auditing. She stated that the risks to residents included life-threatening injuries, pain, fracture, infection.</p> <p>The facility provided the following in-service training topics:</p> <ul style="list-style-type: none"> _Pain management, dated 4/10/2025 _Notification of changes, dated 4/10/2025 _Abuse and Neglect, dated 4/10/2025 _Resident Rights, dated 4/10/2025 _Incident reporting/fall assessment, dated 4/10/2025 _Lab and X-ray review and documentation, dated 4/11/2025 <p>The facility also provided 1:1 in-service/coaching record between the DON and LVN A, with topic of X-ray not properly read by nurse and reported incorrect information. Signed and dated by DON & LVN A, dated 4/11/2025.</p> <p>Review of the facility's policy on Notifying Physician of Change in Status , dated 3/11/2023, revealed that The nurse will notify the physician immediately with significant change in status . Abnormal lab, x-ray and other diagnostic reports require physician notification.</p> <p>The IJ was removed on 4/11/2025 because the facility implemented actions that corrected the the IJ prior to 4/23/2025 entry.</p>		

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<p>F 0777</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51047</p> <p>Based on observation, interview, and record review, the facility failed to promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders for 1 (Resident #1) of 4 residents reviewed for quality of care.</p> <p>LVN A failed to read an abnormal x-ray result, resulting in Resident #1 experiencing pain with a hip fracture for 2 days before Resident #1 was hospitalized for evaluation.</p> <p>A past noncompliance Immediate Jeopardy was determined to have existed from 4/8/2025 to 4/10/2025. While the IJ was removed on 4/11/2025, the facility remained out of compliance at a scope of isolated and a severity of no actual harm with the potential for more than minimal harm to resident health or safety due to the facility's need to implement corrective systems. The facility implemented actions that corrected the IJ on 4/11/2025 before the surveyor's entry.</p> <p>This failure could place residents at risk of delayed medical evaluation, treatment, and decrease in quality of care.</p> <p>Findings included:</p> <p>Review of Resident #1's face sheet, dated 4/23/2025, revealed resident was a [AGE] year-old female admitted on [DATE] with diagnoses of muscle weakness, dementia, and hypertension.</p> <p>Review of Resident #1's MDS assessment, dated 2/17/2025, revealed that resident's BIMS score was 4 out of 15 , indicating Resident #1 has low cognitive function.</p> <p>Review of Resident #1's nursing note, dated 4/8/2025 at 1:54pm, LVN B performed pain assessment which showed Resident #1 was in pain on her left hip and left waist. LVN B notified NP at 10:17am, LVN B notified Resident 1's family member[at 11:16am, stat X-ray was ordered.</p> <p>Review of nursing note, dated 4/8/2025 at 10:24pm, LVN A stated X-ray result faxed to NP for review no new orders.</p> <p>Review of Resident #1's nursing note, dated 4/10/2025 at 10:18am, LVN B noted [Resident #1] complains of pain to left side of body . Routine pain managements appear to be not effective as resident continues to complain of increased pain . Resident appears to be dragging left leg when attempting to make a step. All previous X-ray results to bilateral hips and waists and chest X-ray were negative. LVN B also noted that NP was consulted, EMS was called, and Resident #1's grandson was notified.</p> <p>Review of hospital record, dated 4/10/2025, revealed that x-ray done on 4/10/2025 at the hospital showed fracture to the left hip. Treatment in the hospital included pain management with Tylenol and Robaxin.</p> <p>(continued on next page)</p>		

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<p>F 0777</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of Resident #1's bilateral hips X-ray result, dated 4/8/2025, revealed that the impression of her left hip X-ray was stable acute appearing nondisplaced fracture noted of the superior and inferior of the left pubic rami (left pelvic fracture).</p> <p>In an observation and interview on 4/23/2025 at 12:30pm, Resident #1 was sitting in her wheelchair in the dining room. Resident #1 stated that she did not remember why she fell , but she remembered having a fracture. She stated that she was still having some discomfort from the fall, especially when she had to shift herself in the wheelchair. She stated that the pain had been interfering with her activities of daily living but she stated that pain was improving.</p> <p>In an interview on 4/23/2025 at 12:15pm, LVN B stated that on 4/8/2025, LVN B consulted the NP to order a stat X-ray because Resident #1 was still complaining of pain. When she left her shift on 4/8/2025, the result had not come back, so she relayed the message to LVN A to look out for the result. LVN A read the result on the evening of 4/8/2025, and reported to LVN B on morning of 4/9/2025 as negative via verbal reporting. LVN B did not look at the report and only took LVN A's verbal report. LVN B stated that when Resident #1 was sent to the hospital on 4/10/2025, she retrieved the X-ray report on 4/8/2025 from Resident #1's chart and realized that LVN A has misread the result.</p> <p>In an interview on 4/23/2025 at 1pm, the NP stated that she could not remember exactly what happened, but she remembered Resident #1 had 2 negative X-rays. She stated the fax of the second X-ray result on 4/8/2025, never got to her so LVN A called her to read the X-ray result verbally.</p> <p>On 4/23/2025 at 2:45pm, an attempt to interview LVN A via phone was unsuccessful.</p> <p>An Immediate Jeopardy (IJ) was determined to have existed from 4/8/2025 to 4/10/2025. The facility Administrator was provided the Immediate Jeopardy Template on 4/23/2025 at 3:39pm.</p> <p>Review of the facility's Provider Investigation Report, dated 04/11/25, revealed:</p> <p>The charge nurse will notify NP/MD of any changes of condition noted in a resident. If there is no response from either, the charge nurse will call again and if no answer they will send the resident to the ER .</p> <p>. Any fractures must be reported to DON/ADON as soon as the charge nurse becomes aware of them. Along with faxing X-ray results you must call the NP/MD and document notification.</p> <p>. Failure to review X-ray findings timely could delay care and be considered neglect.</p> <p>.ADON/DON will have all labs and X-ray results in the morning meeting to review daily.</p> <p>Labs and X-ray reports must be reviewed upon receipt. This involves reading the whole lab or x-ray report first page to however many pages follow. Once the report is read and there are abnormal findings the physician or NP must be called; this is not an option. After notifying them of the report the nurse is to document MD notification of x-ray report .</p> <p>(continued on next page)</p>		

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<p>F 0777</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>In an interview on 4/23/2025 at 3:40pm, LVN C, who was a night shift nurse, stated that when he received an x-ray result, he would fax it to NP/MD, then call them to report the result, read every single page on the report, and report to ADON/DON. He stated that the risk of not reading the x-ray result correctly put the residents at risk for more pain and incorrect care. He was in-serviced about reading x-ray results and reporting to NP/MD 2 weeks ago.</p> <p>In an interview on 4/23/2025 at 3:48pm, LVN D, who was a day shift nurse, stated that the process of reporting x-ray result to NP/MD included: receiving the result, reviewing the result by reading all pages, calling NP/MD to report, and faxing the result to NP/MD, reporting to ADON/DON if any results came back abnormal. She stated the risk of reading incorrect results could lead to residents having increased pain, and risk of infection. She stated she was in-serviced a few weeks ago.</p> <p>In an interview on 4/23/2025 at 3:58pm, RN E who was a wound nurse, stated that she had not had to call NP/MD to report an imaging result. She stated she was in-serviced a couple of weeks ago. She stated that the process of report any abnormal labs or imaging results included: receiving the results, if abnormal, notify ADON/DON and NP immediately, read the result every single page, call NP/MD, fax the reports to NP/MD. She also stated that ADON/DON and Administrator met with all nurses to talk about the incident on 4/8/2025. She stated that the in-service included training all nurses to read all pages of reports and fax reports to the correct numbers.</p> <p>In an interview on 4/23/2025 at 4:17pm, LVN F, who usually worked weekend shifts, stated that once he received an anormal lab or abnormal imaging result, he reported to NP/MD and ADON/DON immediately. He also stated that ADON/DON also started going over 24-hour reports with all nurses every morning to look at any abnormal lab results or imaging findings.</p> <p>In an interview on 4/24/2025 at 11:30am, the DON stated that when Resident #1 was sent to the hospital on 4/10/2025, the DON, regional nurse, and all nurses reviewed Resident #1's clinical records to see what they missed and why the Resident #1 continued to have pain. DON stated they realized after looking at the X-ray on 4/8/2025 they had missed the fracture result. LVN A was in-serviced immediately. DON stated that LVN A told her she only saw 1 page of the report and that page stated no fracture, so she reported a negative result to the NP. The DON stated that all nurses were in-serviced immediately. The new process included: all nurses to let the DON know of any abnormal lab or imaging results, and report to NP/MD. ADON and DON would go over each resident's 24-hour report during every morning meeting to review all labs and imaging results. DON also stated that she printed out a sticker listing correct fax numbers for NP and MD at all nurse stations. DON stated that she expected nurses to do their own auditing after they report results to NP/MD and during morning meeting ADON/DON would do second layer of auditing. She stated that the risks to residents included life-threatening injuries, pain, fracture, infection.</p> <p>The facility provided the following in-service training topics:</p> <ul style="list-style-type: none"> _Pain management, dated 4/10/2025 _Notification of changes, dated 4/10/2025 _Abuse and Neglect, dated 4/10/2025 _Resident Rights, dated 4/10/2025 <p>(continued on next page)</p>		

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