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	06/10/2025

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the right to be free from misappropriation of resident property for 1 of 4 (Resident #2) reviewed for misappropriation of property. The facility failed to ensure Resident #2's debit card was secured from unauthorized use of $11,735 when 25 unauthorized withdrawal transactions occurred between 2-12-2025 and 3-13-2025. This failure could place residents at risk for decreased quality of life, misappropriation of property, and financial hardship. Findings included: Record review of Resident #2's admission record dated 6-10-2025 indicated a [AGE] year-old female admitted to the facility on [DATE] with a primary diagnosis of Gram-Negative Sepsis (a life-threatening response of the body to an infection caused by gram-negative bacteria that is unknown), and secondary diagnoses of morbid obesity, hypokalemia (low levels of potassium in the blood), muscle atrophy (loss of muscle tissue decreasing in size/strength), and kidney failure. Record review of Resident #2's Quarterly MDS assessment dated [DATE] revealed that Resident #2 had a BIMS Score of 15 indicating she was cognitively intact. Record review of Resident #2's Care Plan dated 12-9-2024 indicated Resident #2 had an ADL deficit requiring assistance with clothing, personal hygiene, two staff transfers from wheelchair to bed, and toileting. Record review of Resident #2's progress notes revealed the following: 3-24-2025 at 10:08 AM revealed [the former social worker] stated [Resident #2] reported that she had money missing from her bank account. When the [former SW] went to speak to [Resident #2], she did not want to talk about the incident saying I've talked about this all morning, and I don't want to talk about it anymore [because] the bank was investigating the issue. [The former SW] did not ask any more questions but did ask how much money was missing and [Resident #2] said $11,000. -[On] 03.24.2025 two [police]officers arrived at the facility to follow-up on an alleged allegation of resident misappropriation of funds. When the [2 police officers] entered the room of [Resident #2] [Resident #2] said to the police that she didn't need to deal with it and that the bank was taking care of it . and did not want [the police] involved. The police provided the facility with case #L25083P0216. (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's admission policy revealed the facility did not offer to protect resident's property or valuable items. Record review of Resident #2's unauthorized ATM cash withdrawals, received from Resident #2's Bank Fraud Investigator, revealed the following in military time (24-hour clock): 2/12/2025 12:25 $405.00 P287233 2/12/2025 12:26 $506.25 P287233 2/13/2025 6:09 $506.25 P287233 2/13/2025 6:11 $405.00 P287233 2/14/2025 6:29 $506.25 P287233 2/14/2025 6:30 $405.00 P287233 2/15/2025 13:34 $506.25 P287233 (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/15/2025 13:36 $405.00 P287233 2/17/2025 8:04 $506.25 P287233 2/17/2025 8:05 $405.00 P287233 2/25/2025 9:24 $506.25 P287233 2/25/2025 9:25 $405.00 P287233 2/26/2025 9:47 $506.25 P287233 2/26/2025 9:48 $405.00 P287233 3/3/2025 5:55 $506.25 P287233 (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/3/2025 5:56 $405.00 P287233 3/4/2025 6:09 $800.00 PX3658 3/5/2025 9:54 $506.25 P287233 3/5/2025 9:54 $405.00 P287233 3/11/2025 13:02 $506.25 P287233 3/11/2025 13:03 $405.00 P287233 3/12/2025 6:19 $506.25 P287233 3/12/2025 6:20 $405.00 P287233 (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/13/2025 8:47 $506.25 P287233 3/13/2025 8:48 $405.00 P287233 In an interview with Resident #2's Bank Fraud Investigator, on 6-10-2025 at 10:30 AM, it was revealed that one of Resident #2's caregivers, who worked at the facility, made 25 (unauthorized) ATM cash withdrawals between 2-12-2025 thru 3-13-2025 totaling $11.735.00. The Bank Fraud Investigator said video footage indicated a black female (Brown hair, brown eyes, medium brown complexion) in burgundy scrubs driving a silver sedan made the cash withdrawals using Resident #2's bank card. The Bank Fraud Investigator said Resident #2 was a caucasian female. In an interview with Resident #2 on 6-10-2025 at 12:00 PM, it was disclosed that Resident #2 informed the facility, at the end of March 2025, that money was missing in her bank account. Resident #2 said the facility contacted the [HHSC] and local police. Resident #2 said the facility did not inform her that they could protect her bank cards from fraud. Resident #2 said she admitted to the facility in December 2024 and received her bank card at the facility. Resident #2 said whoever used her debit card, got the pin # and the debit card, from her room because the debit card was never taken out of her room by her. Resident #2 said she had let one or two staff members use her debit card to get a soft drink out of one of the facility's vending machines, but she does not remember who they were. Resident #2 said she has not left the facility since admission. Resident #2 said whoever used her debit card, without her permission, always put the card back in her room because she never noticed it missing. Resident #2 said the theft of her money, from her debit card, made her feel stupid. Resident #2 said her bank has deactivated the debit card that was fraudulently used. Resident #2 said a new debit card was issued and can only work online. Resident #2 said she has not had any money or property stolen from her since March 2025. Resident #2 said she feels safe now but does not trust people. In an interview with the facility's SW on 6-10-2025 at 4:40 PM, it was revealed the SW has worked at the facility since 4-2025. The SW stated she did not know how the facility would protect resident's property. The SW said there have been in-house investigations and in-services on misappropriation of resident's property to curtail misappropriation from occurring. The SW said she was not familiar with Resident #2's missing money. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Administrator on 6-10-2025 at 5:20 PM, it was stated the former SW was informed of Resident #2's missing money on 3-24-2025 and the Administrator was informed after that. The Administrator said he attempted to speak with Resident #2 about her missing money, but Resident #2 refused to talk to him about it. The Administrator said he reported the incident to the State Health and Human Services Commission and the local police. The Administrator said the result of THHSC investigation was unsubstantiated. Information from Resident #2's Bank Fraud Investigator was given to the Administrator. The Administrator said he was going to follow up with the local police department again to see if he could find out who the perpetraitor was. The Administrator said Resident #2 refused to speak with the State and local police when they came to the facility. The Administrator said residents were informed, in their admission packet, that there was a trust fund they could put their money in. The Administrator said, before Resident #2 had money stolen, the facility did not know Resident #2 was keeping her debit card in her room. The Administrator said the facility had lock boxes residents could use to put their valuables in, but it was not mentioned in the admissions packet. The Administrator said that he had not told Resident #2 that she could put her debit card in a lock box but he was going to now. The Administrator said that he was responsible to ensure residents valuables, bank cards, and credit cards were kept safe as much as possible. The Administrator said the potential harm to residents having their property stolen was emotional and financial distress. Record review of the facility's in-service training dated 3-24-2025 revealed they conducted facility wide training on misappropriation of funds. Record review of the facility's Abuse and Neglect policy, undated and titled Abuse/Neglect, stated: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart . Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers .[9] Misappropriation of resident property: means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent . G. Protection - The facility will take necessary measures to protect residents and employees from harm during and following . misappropriation of resident property investigation.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property for one (Resident #1) of four residents reviewed for abuse. The facility failed to ensure CNA A, who was suspended on 05/28/2025 due to Resident #1 alleging CNA A verbally abused Resident #1, did not provide care to Resident #1 when CNA A came back to work after being suspended. This failure could place residents at risk for abuse, neglect, and/or exploitation. Findings included: Record review of Resident #1's face sheet dated 06/10/2025 revealed a [AGE] year-old female admitted to the facility on [DATE] with a readmission on [DATE]. Admitting diagnosis including Multiple Sclerosis (a disease in which the immune system Eats away at the protective covering of nerves); Paraplegia, incomplete (the spinal cord is damaged but not completely severed, allowing for some level of movement or sensation below the injury); Bipolar Disorder, Current Episode Manic Severe with Psychotic Features (occurs when a person experiences an episode of severe mania or depression along with psychotic symptoms and hallucinations causing sudden changes in mood from excessive happiness, joyful to being angry and hostile). Review of Resident #1's quarterly MDS dated [DATE] revealed, a BIMS score of 99, meaning the resident was unable to complete the interview. The MDS also revealed the resident recalls staff's names, faces, and she resides in a nursing facility with memory severely impaired. Resident #1 exhibits physical and verbal behaviors and requires extensive assistance with ADLS. Review of provider investigation report dated 05/28/2025 revealed, An email received on 05/28/2025 at 3:03 PM from the LCSW with the psychological services to the ADM revealed the description of the allegation made by Resident #1 accusing CNA A and CNA B of abuse while attempting to provide ADL care in her room. Investigation Summary: The investigation summary found to be inconclusive. Provider Action Taken: Monitor resident for emotional distress. Post -Investigation: The facility reinstated the alleged perpetrators and conducted in-services including abuse/neglect prevention. Review of an undated witness statement attached to the facility self-report provided by ADM revealed Date of alleged incident: 05/28/2025 LCSW from psychological services notified ADM that Resident #1 reported that two male CNAs providing care to her abused her. Resident #1 alleged that CNA A called the resident a delusional bitch and alleged CNA B fingered her vagina and bottom when in the shower due to boo boo. On 06/10/2025 at 3:15 PM interview with Resident #1 revealed resident did not recall the incident that occurred with the two male CNAs. Resident #1 was speaking about different topics within her conversation. The conversation was hard to follow due to her confused state. Resident #1 was in good spirits, calm, and happy. She was not showing any agitation or aggression. Resident #1 stated she stays in bed most of the time and watches her TV. She voiced no concerns and did not mentioned incident between she and the CNAs. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/10/2025 at 3:30 PM with CNA A revealed that he was still providing care for Resident #1 . The facility now required two CNAs to go into the room to care for the resident. CNA A stated that he knows the resident has mental issues and he tries to approach her gently and not upset her. He was only trying to do his job. He enjoyed caring for her but knows that he must be on guard due to her behaviors. CNA A revealed he did not hurt her in any way while providing care. Interview on 06/10/2025 at 3:53 PM, attempted to contact CNA B by phone but was unable to speak with him. Left a message on his voicemail. Interview on 06/10/2025 at 4:20 PM with Administrator revealed the documentation in the investigation was provided by the LCSW with the psychological services for Resident #1. The Administrator stated that there will be two CNAs assigned to Resident #1 when providing care. The Administrator revealed that there would be no male CNAs caring for Resident #1 and two CNAs would provide care. The Administrator stated that both CNAs were suspended and have returned to work. They were not to be assigned to Resident #1 any longer. The Administrator stated if CNA A and CNA B were to continue to provide care to Resident #1, the harm would be resident would be afraid of both CNAs. Interview on 06/10/2025 at 6:00 PM with DON revealed CNA A and CNA B have returned to work. CNA B worked PRN for the facility. The DON stated that CNA A and CNA B were not to provide care or go into Resident #1's room at all. The Charge Nurse for the hall made the room assignments for the CNAs each day. The Charge Nurse had been told not to assign CNA A or CNA B to Resident #1 . The DON stated there would no longer be a male CNA assigned to care for Resident #1. The DON expected both CNAs not to go into Resident #1's room even if to answer her call light. The DON revealed that if CNA A and CNA B continue to provide care to Resident #1, the harm would be resident could experience emotional distress and trauma. On 06/12/2025 at 4:02 PM interview with CNA B revealed that he works PRN for the facility. CNA B revealed that he was not assigned to care for Resident #1 at the time she made the allegation. CNA B has not taken care of Resident #1 since he has returned to work. Record review of facility policy r/t Resident Abuse and Neglect (no policy date noted) revealed in part, Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being.