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	09/04/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure residents who needed respiratory care were provided such care, consistent with professional standards of practice for 1 of 2 (Resident #2) residents reviewed for respiratory care. The facility failed to ensure there were cautionary and safety signs indicating the use of oxygen outside Resident #2's room where oxygen was used. These failures placed the residents at increased risk of injury due to fire hazards.Record Review of Resident #2's admission Record dated 09/04/2025 revealed she was a [AGE] year-old female admitted to the facility on [DATE] with a primary diagnosis of Cerebral Infarction(-stroke), and secondary diagnosis of Chronic Respiratory Failure with Hypoxia (condition where the lungs do not function properly) and Tracheostomy status (Presence of tracheostomy in which a hole is made in the front of the neck to the windpipe, known as the trachea, which a tube is placed to keep it open for breathing).Record Review of Resident #2's Order Summary Report dated 09/04/2025 revealed order for 2 LPM via nasal cannula when trach is capped during the day, oxygen via trach daily every day shift for oxygen related to Chronic Repository Failure with Hypoxia. During an observation and interview on 09/04/2025 at 09:52 AM with Resident #2 revealed she was sitting up on the side of bed, wearing oxygen via nasal cannula connected to an oxygen concentrator running at 2 LPM and Tracheostomy capped off. She did not voice any concerns about her oxygen intake. There was no sign outside her room indicating oxygen use. Interview on 09/04/2025 at 2:11 PM with ADON revealed there was not a set individual responsible for making sure oxygen signage was posted on Resident #2's door. He stated the risk of not having oxygen in use signage was so no one will blow up and not to mix and match chemicals. The importance of oxygen in use signage was to let others know which residents have oxygen. Interview on 09/04/2025 at 3:36 PM with DON revealed, the DON and ADON are responsible for ensuring oxygen in use signage was placed on the Resident's door, to alert staff not to use petroleum jelly around her nose and nothing flammable. The risk was possible harm to the resident. Review of facility's policy and procedure titled, Oxygen Administration undated revealed; 11. Place No SMOKING signs in area when oxygen was administered and stored. Store oxygen cannister in areas free of flammable substances. Avoid the use of electrical appliances in the area of oxygen use as well .

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews the facility failed to ensure pain management was provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 1 resident (Resident #1) reviewed for pain management. The facility failed to follow their pain management policy when Resident #1's response to pain medication was not monitored and effectiveness was not recorded.This failure could place residents at risk of uncontrolled pain.Findings included:Record review of Resident #1's admission record, dated 09/04/2025, revealed a [AGE] year-old female who admitted to the facility on [DATE] with type 2 diabetes (a disease that occurs when the body does not respond properly to insulin leading to high blood sugar levels) and dementia (brain disease that alters brain function and causes a cognitive decline). Record review of Resident #1's BIMS assessment, dated 08/27/2025, revealed a score of 2, indicating severe cognitive impairment. Record review of Resident #1's progress notes, dated 09/01/2025, written by LVN H revealed, Resident noted with swelling and bruising on the right wrist, with discoloration observed. Per previous report, findings are possibly related to delayed injury from a recent fall. NP assessed resident during unit visit and provided new orders: X-ray 2-view of right hand and application of ice pack BID x 3 days. Safety maintained; resident monitored for pain and further changes.Record review of Resident #1's Event Follow up note, dated 09/01/2025, written by LVN H revealed, in part .New orders: 2 view x-ray to the right wrist Due to pain /bruising and swellingName of MD/NP notified: [Name] NP Date/time of notification: 09/01/2025 12:00 PMName of RP notified: [Name] Date/time of notification: 09/01/2025 12:00. Record review of Resident #1's progress notes, dated 09/01/2025, written by LVN H at 8:20 PM revealed, Nurse on [shift] following up on X-ray order placed this morning, called X-ray provider, [Provider Name] twice, and received no answer from the receiving end. report given to oncoming nurse to monitor and report on pending stat X RAY to be done.Record review of Resident #1's progress notes, dated 09/01/2025, written at 10:45 PM by LVN G revealed, Resident in bed sleeping with eyes closed after shift report. Respirations even and non-labored. HOB elevated 30-35 degrees. No signs of any respiratory distress or SOB noted. Right wrist swelling and bruising in place as per report received from 0600-2200 (6:00 am - 10:00 pm) shift nurse. No signs or symptoms of any discomfort noted when site lightly palpated. VS- R. 20, O2 Sats 95RA, B/P 133/74, P. 70, T. 97.3. Right wrist elevated to decrease swelling. Resident continues on Ice pack application to sited as ordered while waiting for X-Ray to be done/ report. Bed placed in lowest position with bolsters and floor mat in place for safety. Continue to monitor resident.Record review of Resident #1's progress notes, dated 09/02/2025, written by LVN H at 2:34 PM revealed, Resident's right wrist remains swollen. Ice pack applied as ordered for pain and swelling. Nurse followed up with [Provider Name] regarding X-ray order; confirmed X-ray technician scheduled to arrive today for imaging. [RP, Name] was notified and requested ongoing updates on the resident's progress. Safety and comfort maintained. Will continue to monitor.Record review of radiology report, dated 09/02/2025, revealed RIGHT TIBIA(shinbone)/FIBULA(calf bone) SERIES Findings: Examination of the right tibia/fibula demonstrates no evidence for fracture. There are no bony abnormalities. The soft tissues are unremarkable. IMPRESSION: Negative Study.Record review of Resident #1's progress notes, dated 09/02/2025, written by LVN H at 10:13 PM revealed X-ray results of the resident's right wrist faxed to NP; findings indicate no fracture. NP recommended continued icing and elevation of the arm on a pillow. New order was received to apply a sling to the right hand while the resident is awake. Safety and comfort maintained. Will continue to monitor.Record review of Resident #1's progress notes, dated 09/03/2025, written by LVN G at 4:34 AM revealed, Resident right wrist elevated as tolerated d/t swelling. Bruise intact and clearing. No signs of any discomfort noted when resident wrist assessed. VS- R. 20, O2 Sats 95%RA, B/P 129/77, P. 76, T. 97.4. Bed in lowest position with bolsters in place and floor mat in place and close to bed for safety. Call light in reach.Record review of Resident #1's progress notes, dated 09/03/2025, written by LVN B at 9:53 AM revealed resi alert w/ large bruise to R hand. no SOB or acute resp distress observed. N/O received to send resi to ER of [Hospital Name] in [City] for further evaluation and treatment due to large bruise to R hand. VS taken & WNL w/ 129/77 63 19 97.8 97 and BS 128. Routine ice pack + PP admin w/ positive outcome. EMS was called and transported resi out of facility at 10:05am. resi [RP Name] was informed of resi being transported.Record review of Resident #1's progress notes, dated 09/03/2025, written by the DON at 10:09 AM This Called resident [RP], and received call back, regarding

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. (continued on next page)

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews the facility failed to provide or obtain radiology services to meet the need of its residents for 1 of 1 Residents (Resident #1) reviewed for radiology services. The facility failed to correctly order and follow up on stat x-ray. Resident #1 did not get an x-ray for more than 24 hours after a stat x-ray was ordered. The x-ray performed was performed on the leg instead of the wrist.This failure could place residents at risk of delayed treatment, and pain.Findings included:Record review of Resident #1's admission record, dated 09/04/2025, revealed a [AGE] year-old female who admitted to the facility on [DATE] with type 2 diabetes (a disease that occurs when the body does not respond properly to insulin leading to high blood sugar levels) and dementia (brain disease that alters brain function and causes a cognitive decline). Record review of Resident #1's BIMS assessment, dated 08/27/2025, revealed a score of 2, indicating severe cognitive impairment. Record review of Resident #1's progress notes, dated 09/01/2025, written by LVN H revealed, Resident noted with swelling and bruising on the right wrist, with discoloration observed. Per previous report, findings are possibly related to delayed injury from a recent fall. 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N/O received to send resi to ER of [Hospital Name] in [City] for further evaluation and treatment due to large bruise to R hand. VS taken & WNL w/ 129/77 63 19 97.8 97 and BS 128. Routine ice pack + PP admin w/ positive outcome. EMS was called and transported resi out of facility at 10:05am. resi [RP Name] was informed of resi being transported.Record review of Resident #1's progress notes, dated 09/03/2025, written by LVN H at 4:45 pm revealed Resident returned from [Hospital Name] with diagnosis of closed fracture distal end of R radius (broken right wrist). Seen by NP during rounds; new orders: Tramadol 50 mg PO BID PRN pain, d/c Tylenol 650 mg, start Tylenol 1 g PO q8h PRN pain. Splint to remain on at all times; sling when OOB; wrist brace and thumb spica splint in place. Resident repeatedly removed dressing and sling; nurse reapplied several times. [Family member] notified of resident's return; verbalized availability for contact, will visit tomorrow. Resident resting in bed; safety and comfort maintained.Record review of hospital x-ray results, dated 09/03/2025, revealed the following: Findings: Discontinuity of the cortex of the central articular surface of the distal radius (wrist) seen on the lateral (side) view only. Nondisplaced fracture (bones remain in alignment) of indeterminate age (unknown if new or old) cannot be excluded. No other fractures. Moderate osteoarthritis (common joint condition that causes pain, stiffness) at the radiocarpal (wrist) join t and first carpometacarpal (base of thumb) joint, No dislocation. No lytic (areas of bond destruction that result in holes) or blastic (areas of abnormal growth) lesions. Impression:Nondisplaced fracture of indeterminate age at the distal radius articular surface Record review of intake investigation