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	01/29/2026

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

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to develop and implement a baseline care plan for each resident which included the instructions needed to provide effective and person-centered care of the resident that met professional standards of quality care or ensure a comprehensive care plan was developed in place of the baseline care plan if the comprehensive care plan was developed within 48 hours of a resident's admission for one of three residents (Resident #1) reviewed for baseline care plans. Teh facility failed to develop a baseline care plan within 48 hours of Resident #1's admission. This failure could place residents at risk of not receiving appropriate care upon their admission to the facility. Findings include: Review of Resident #1's face sheet, dated 01/29/26, reflected he was a [AGE] year-old male, admitted on [DATE], with diagnoses of dementia, an anxiety disorder, chronic pain, and metabolic encephalopathy (a brain dysfunction caused by other health condition, which fluctuates and can lead to confusion, memory issues, personality changes, and other problems.) Review of Resident #1's care plan page of his EMR, on 01/29/26 at 10:09 AM, reflected no care plans. Review of Resident #1's MDS page of his EMR reflected his admission MDS was still being edited (due to his recent admission date.) Review of Resident #1's progress notes reflected the following:- admission notes, dated 01/23/26, by LVN C reflected Resident #1 was admitted to the secured unit of the facility, from another nursing facility, lying on a stretcher. The note contained observable information about Resident #1, which included his vital signs at admission, and information indicating he had poor memory, used a wheelchair, and required 2-person assistance for transferring, hygiene and bathing. The notes reflected a skin assessment was done by LVN C, during which various bruising, and small scabs were observed on Resident #1's body.- A note by ADON D: Effective Date: 01/23/2026 (1:44 PM) [TF4] Type: Nursing Note: Late Entry Note Text : A copy of the baseline care plan was provided to the resident A copy of the baseline care plan was provided to the resident representative Date/time provided: 01/27/2026 12:00 AM- Notes from 01/23/26 through 01/29/26 reflected various care concerns, which included, but did not end with Resident #1's fall risk and actual falls, skin tears, hospice service, agitation, and confusion. Review of Resident #1's Baseline Care Plan Acknowledgment form, dated 01/27/26, reflected the resident and his representative were given a copy of the baseline care plan, for his admission on [DATE]. Review of Resident #1's care plan page of his EMR on 01/29/26 at 2:19 PM reflected care plans including, but not limited to care areas of ADLs, medications, skin condition and risks, cognitive status/ dementia, communication, falls and fall risk, and behavioral, all with the date initiated being 01/29/26. An interview on 01/29/26 at 10:15 AM with LVN C revealed she did not know where the baseline care plans were kept, but she did admit Resident #1 and put all his information in his admission note. An interview on 01/29/26 at 11:10 AM with the Regional RN revealed ADON D was the person who provided the baseline care plan acknowledgment to Resident #1's responsible party. She said the way the baseline care plans were made was the staff opened up the (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 - 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** Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and interventions to meet a resident's medical and nursing needs that were identified in the comprehensive assessments for 1 of 5 residents (Resident #3) reviewed for care plans.The facility failed to develop a care plan for Resident #3 to address anticoagulant medication use. This failure could place residents at risk for not receiving proper care and services.Findings included:Record review of Resident #3's face sheet, dated 01/29/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. Resident #3 had a primary diagnosis cerebral infarction (blood clot forms in artery, disrupting blood flow to the brain, resulting in stroke). Other pertinent diagnoses included dementia (decline in cognitive function), sepsis (body's overwhelming response to infection, can lead to tissue damage and organ failure), obstructive and reflux uropathy (blockage in the urinary system that prevents normal urine flow), and acute kidney failure (kidneys suddenly lose ability to filter waste products from the blood). Record review of Resident #3's BIMs (a standardized assessment to measure long and short-term memory) assessment, dated 12/12/2025, reflected a score of 3, which indicated severe cognitive impairment. Record review of Resident #8's anticoagulant order, dated 01/29/2026, reflected: Eliquis Oral Tablet 2.5 MG (Apixaban) Give 1 tablet by mouth two time a day for clotOrder status: Active Start date: 08/21/2025. Record review of Resident #3's care plan, revised 12/20/2025, did not reflect a care plan for anticoagulants. Attempted interview on 01/29/2026 at 11:02 A.M. with Resident #3, revealed the resident did not communicate with the state surveyor. During an interview on 01/29/2026 at 4:40 P.M. with the Regional RN, she stated there should be a care plan for anticoagulant medication. The Regional RN said the care plan assisted with letting staff know if the residents had adverse reactions. She discussed interventions would include monitoring the resident every day and CNAs could do that because they looked at the resident's skin every day . During an interview on 01/29/2026 at 4:50 P.M. with ADON E, she revealed she was responsible for part of completing the care plan, which included acute care, antibiotic medications, and falls. She stated signs staff look for in residents who took anticoagulants included signs of bruising and bleeding and it was a part of the tasks for nursing staff to look for bruising and bleeding. ADON E said during rounds in the morning, the ADONs asked questions, which included if anything changed or if there was anything they needed to know about (regarding residents). During an interview on 01/29/2025 at 5:45 P.M. with the ADM, she revealed the risk of not care planning for medications like anticoagulants was residents could be prescribed something they should not be getting or be taking another medication that could result in medication interaction. Record review of the facility's, undated, Comprehensive Care Planning Policy, reflected: Comprehensive Care PlanningThe 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 describe the following - The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; and the right to refuse treatmentAny specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASAR (preadmission screening and resident review) and the resident's representative(s)-The resident's goals for admission and desired outcomes.The resident's preference and potential for future discharge. The facility document whether the resident's desire to (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.Discharge plans in the comprehensive care plan, as appropriate.Each resident will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the resident's medical, physical, mental, and psychosocial needs.

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F 0689 Level of Harm - Minimal harm or potential for 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** Based on observation, interview and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for one of three residents (Resident #1) reviewed for supervision. CNA A and CNA B failed to safely transfer Resident #1 when they supported the resident under his arm-pits and with a gait belt while lifting him from the floor to his wheelchair, instead of using a mechanical lift. This failure could place residents at risk of injury.Findings included: Review of Resident #1's face sheet, dated 01/29/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included dementia, an anxiety disorder, chronic pain, and metabolic encephalopathy (a brain dysfunction caused by other health condition, which fluctuates and can lead to confusion, memory issues, personality changes, and other problems.) Review of Resident #1's MDS page of his EMR reflected his admission MDS was still being edited (due to his recent admission date.) Review of Resident #1's care plans, initiated on 01/29/26, reflected care plans which included the following:- ADL self-care deficit, with interventions including two-person assistance bathing and bed mobility.- risk of falls related to dementia, diagnoses, and unfamiliar surroundings, with interventions including two-person assistance with transfers. No assistive devices were referred to in the care plan.-use of, and monitoring for side effects of, antidepressant, anti-psychotic, and anti-anxiety medications Review of Resident #1's progress notes:- admission notes by LVN C on 01/23/26 reflected Resident #1 was admitted to the facility via EMS, on a stretcher, accompanied by a family member. He had large bruises to the fronts and back of his knees, and to his outer thigh area. Resident #1 required two-person assistance for bed mobility (moving himself around in his bed), transferring, dressing, bathing, and hygiene, and one-person assistance for eating, and used incontinence briefs/pads. He used a wheelchair most of the time, but was unable to use devices or comprehend instructions, due to his poor cognition. It was noted that his ability to make daily decisions was poor, and he required reminders, cues, and supervision in planning, organizing, and correcting daily routines. He was alert, had short-term memory problems, and was oriented to person.- A skilled nurse note by LVN F on 01/25/26 reflected Resident #1's bed was lowered for safety (as a precaution against fall injury.)- A skilled nurse note by LVN G on 01/25/26 reflected Resident #1 was combative, agitated, did not call for assistance, and resisted being redirected. The note indicated additional fall precautions (air mattress and fall mat by bed) and close monitoring were put in place.- A nursing progress note by LVN H reflected Resident #1 had an unwitnessed fall and was found next to his bed on the fall mat, with a skin tear on his elbow, but no other injuries. Review of Resident #1's Fall Risk Assessment, effective 01/24/26, reflected he was a high risk for falls due to a history of one to two falls in the past three months, intermittent confusion, being chair-bound, inability to stand, and taking multiple medications which could contribute to fall risk within the past seven days. An observation on 01/29/26 at 9:47 AM revealed Resident #1 was sitting on the floor in the dining area, in front of his wheelchair, and LVN C ran to help him, while calling for CNA A and CNA B to assist. LVN C assessed Resident #1. Found no evidence of injuries, and asked CNA A and CNA B to transfer him back to his chair. The CNAs transferred Resident #1 back to his chair by placing a gait belt on him, getting on either side of him, facing him, both grabbing the gait belt in the back, and using their other arms to place their forearms directly under each of Resident #1's arm pits, and lifting. During the lift, the gait belt slid up Resident #1's back, and the resident appeared to not assist in the transfer at all, causing the CNAs to have to do all of the lifting to place him back in his wheelchair. LVN C took the resident next to the nurses station, and (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sat down next to Resident #1 who leaned forward in his chair. She told him to sit back, and put her hand on his shoulder, and he sat back. She sat next to him for a few minutes, then went inside the nurses' station to document the incident and make notifications. CNA A stayed near and talked to Resident #1, who appeared sleepy and opened his eyes partially, occasionally, and closed them. During this observation, Resident #1 attempted to stand up again, and CNA A reminded him to sit in his wheelchair, and he sat down. An interview on 01/29/26 at 10:15 AM with LVN C revealed Resident #1 was a two-person transfer, was not weight-bearing, and his assessment after this fall showed no signs of injury. She said she notified the DON, the physician, and the responsible party, after she assessed him, and started neuro checks (monitoring done when someone might have hit their head during a fall.) When asked if the CNAs had done a proper transfer of him from the floor to his wheelchair, she said she thought the CNAs were supposed to cup their arms under his and lift him. During this interview, Resident #1 leaned forward and put his hands on the arms of his wheelchair, as if he was going to stand up, and LVN C put her hand on his shoulder and said We aren't going to get up yet, because you could fall again and the resident leaned back in his chair and relaxed. An interview on 01/29/26 at 10:22 AM with OT revealed she had not met Resident #1, but if a resident fell, the staff was to wait for the nurse to assess the resident. She said if the resident was unable to help staff get them off the floor, the staff would use a gait belt, or the hoyer lift. She said there were various methods of getting someone up, depending on the resident's ability and size, and the staff doing the lift. She said there was a way to assist someone up from behind using the gait belt, if the resident was able to sit themselves up, but she would never go under their arms to lift them. She demonstrated how someone could assist someone from behind, which involved putting their arms around the resident and grasping their hands in front of the resident's chest, but did not put stress on the arms or shoulders. She left to go check on Resident #1. An interview on 01/29/26 at 10:41 AM with the DOR revealed the staff should assess a resident who had fallen while they were on the floor, and they should know their limitations in lifting the resident. He said if the staff were not strong enough to lift using a gait belt, they should go get a mechanical lift, and they should always wait until the nurse had assessed the resident. He said if the lift was outside of the resident's or staff's capabilities of lifting safely using the gait belt, they should use the mechanical lift. He said they did training with staff on safe lifting, to make it safer for the residents and the staff. He said they were to never to lift under the arm pits, because the resident could pull a muscle or dislocate their shoulder. He said the ice storm during the time Resident #1 was admitted had interfered with staffing and therapy's evaluation of some residents, who were normally assessed very soon after admission. An interview on 01/29/26 at 11:16 AM with CNA A revealed she had been a CNA for a long time, and the facility had done training on how to lift safely. She said she was not really sure if the way Resident #1 was lifted was the way he was supposed to be lifted, and she was aware someone could be hurt by lifting them under their armpits. She said Resident #1 had been able to assist in being lifted, but only a little bit, and he was weight-bearing, and they had used the gait belt for most of his weight. She said she saw Resident #1 stand up after he was admitted , so she knew he was able to assist in standing, so the way they lifted him was a judgment call and nobody had told her how to lift him. An interview on 01/2926 at 11:38 AM with CNA B revealed they normally transferred Resident #1 with a gait belt, because he helped, but this time he would not help, so they had to get under his arms to transfer him. She said lifting someone under their arm pit could hurt their shoulder, knock it out of place, or cause a fracture. She said the resident was new to the facility, and she had not expected him to be dead weight but should have used the mechanical lift, which was what they normally did (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	if someone could not stand, or bear weight. She said he was total, meaning he could not do any part of the lift by himself, and sometimes he worked with them on transfers, and sometimes he didn't. She said if they were lifting him with the gait belt, they should have used his pants waistband to steady him, not his arms. An interview on 01/29/26 at 12:04 PM with ADON D revealed Resident #1 was new, and when he admitted he thought the resident was unable to bear weight, and had not noticeably changed since his admission. He said Therapy usually screened new residents very quickly after they admitted , usually the day after the admission, but the lingering icy weather had impacted therapy's staffing, as well. After the nurse did a thorough assessment of the resident, the staff should have used a mechanical lift to get him up, and should never lift someone under the armpits. He said they did in-services and skills check-offs with the CNAs to make sure they knew how to properly transfer residents, and they did cover how to get a resident off the floor. An interview on 01/29/26 at 5:29 PM with the Regional RN and ADON E revealed the Regional RN said there were two or three ways to transfer a man in the situation Resident #1 had been in, and none of them ever involved using the resident's arm. She said they could have pulled the resident's arms out of the sockets. ADON E said lifting a resident the way the CNAs had done, it could cause physical trauma or skin tears. The Regional RN said the staff were trained on how to move a resident, but were currently being trained again. She said it was the ADONs' and nursing management's responsibility to make sure the staff knew how to lift, and how to do it right, and they had done training and skills check-offs on all types of transfers. Review of a CNA Proficiency Audit for CNA A, dated 11/26/25, reflected she performed satisfactorily in one-person assisted, two-person assisted, mechanical lift two-person, and ambulatory resident transfers. Review of a CNA Proficiency Audit for CNA B, dated 11/26/25, reflected she performed satisfactorily in one-person assisted, two-person assisted, mechanical lift two-person, and ambulatory resident transfers. Review of the facility's undated policy Moving a Resident Bed to Chair/ Chair to Bed reflected no mention of what to do when a resident was unable to assist in a transfer, or bear weight. The document did reflect: Purpose: The purposes of this procedure are to allow the resident to be out of his or her bed as much as possible and to provide for safe transferring of the resident. Steps in the Procedure: Note: This procedure may require two (2) persons [.] 9. If moving a resident from bed to chair: [.] b. If transferring the resident to a wheelchair: 1. Be sure the wheels are locked; [.] h. Position a gait belt around the resident's waist and clasp it. Make sure it is tight enough that only a slight hand movement will guide the patient, but not so tight that you cannot firmly grasp the belt without making the patient uncomfortable i. If the resident requires, two persons (one on each side) should grasp the gait belt and gently stand and turn the resident and sit him or her in the chair. j. If the resident can assist in this procedure, stand on the resident's weak side. (Note: Encourage the resident to use his or her strong side and to assist in the procedure as much as possible.) k. Support the resident by placing a gait belt around the resident's waist for you to hold and steady the resident. 1. Instruct the resident to turn so that the back of his or her legs are near the chair. m. Instruct the resident to place his or her hands on the arms of the chair for support. n. Move with the resident. o. Be sure the resident is all the way back in the chair. [.] Review of the facility's undated Fall Policy reflected: Appendix A: Fall Intervention Methods: Environmental [.] Staff must be trained in safe transfer techniques and proper use of body mechanics.

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview and record review the facility failed to maintain an effective pest control program so that the facility was free of pests for 1 of 2 halls (Hall 200) reviewed for pest control.1. The facility failed to ensure Hall 200 was free of gnats.2. The facility failed to ensure one room at the south end of the hall was free of gnats.These failures could place residents at risk of infestation of pests and compromise resident health.Findings included: Observation on 01/29/2026 at 9:48 A.M. on the south end of Hall 200 revealed 1 gnat flying around. During an observation and interview on 01/29/2026 at 11:05 A.M. with Resident #2, in her room at the south end of Hall 200, she revealed the gnats had always been an issue. She indicated the gnats were worse, compared to the past. When asked if the gnats bothered her, she said, oh yeah. Resident #2 said she told staff about the gnats, and it could be a topic of conversation for anyone who came into the room. She said as far as she knew the room had been sprayed. This state surveyor counted 3 gnats around Resident #2, and 5 gnats around the sink in the room. Observation of the sink in the room revealed that sink was clean and had no foul odors. Observation on 01/29/2026 at 12:26 P.M. revealed 1 gnat flying around in the north end of Hall 200. Observation on 01/29/2026 at 12:28 P.M. revealed 1 gnat flying around the nurse's station in Hall 200. During an interview on 01/29/2026 at 1:05 P.M. with LVN I, she revealed she saw gnats and was supposed to tell housekeeping if there were gnats in resident rooms. She said pest control had come and sprayed chemicals and it worked. LVN I said the risk of having gnats was they were not good and could fly into residents' mouths, noses, hair, and in their skin. During an interview on 01/269/2026 at 2:56 P.M. with LVN J, she said she saw gnats but not in the whole building. She indicated she saw gnats on a meal tray in a resident room and took the meal tray out of resident's rooms when she saw them. LVN J said maybe food (in the resident rooms) was an issue. She said the risk to residents was it might bite the residents or (residents) would not want to eat the food. She said pest control came when called and she reported pest issues to the administrator. During an interview on 01/29/2026 at 5:45 P.M. with the ADM, she revealed the facility had actively been treating the gnats. She stated the pest control company was recently at the facility and had left treatment for the facility to use to treat the gnats. She said it had been a little better, but it was a known issue and if gnats were seen during rounds the ADM was to notify the (pest control company. Records requested for review on 01/29/2026 at 2:25 P.M. and 02/02/2026 at 2:22 P.M. for the facility's pest control policy and pest control log. The facility only provided the food service department's Insect and Rodent Control policy. A pest control policy for the whole facility and a pest control log was not provided. Record review of the facility's food service department's Insect and Rodent Control policy, dated 2012, reflected: The facility will maintain an effective pest control program in order to provide an insect and vermin free food service department.Procedure:1. Arrangements are made with a reputable company for regular spraying for insects which includes rodent control when required.2. Facility will maintain appropriate screens, close fitting doors, properly sealed water/sewer pipes, structurally maintained walls, baseboards, etc. to prevent entrance access of insects and rodents.3. Sanitation of facility will be maintained per other stated sanitation policies to prevent food sources, breeding places, etc. for insects or rodents.4. Deliveries of food and supplies will be monitored for prevention of insect and rodent access.