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	05/21/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, the facility failed to ensure the resident had a right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely for 3 of 3 shower rooms (Shower room [ROOM NUMBER], Shower room [ROOM NUMBER] and Shower room [ROOM NUMBER]), 1 of 4 residents halls (Resident Hall #2), 1 of 3 linen closets (Linen Closet in 200 hall), 1 or 5 resident bed linens (Resident #6) reviewed for clean homelike environment: The facility failed to provide stain free bed linens for Resident #6 on 5/19/26.The facility failed to ensure all shower rooms were visibly clean and free of debris and trash on 5/22/26.The facility failed to ensure Resident Hall 200 was free from urine on the floor on 5/22/26.The facility failed to ensure the bed linens stocked in the Linen Closet in the 200 Hall were stain free. These failures could place residents at risk of exposure to infectious diseases, other unsanitary health hazards and affect their sense of dignity.Findings Include: Record review of Resident #6's Quarterly MDS Assessment completed on 4/24/26 reflected a [AGE] year-old male admitted to the facility on [DATE] with little to no cognitive impairment and a BIMS score of 13. Resident #6 had the following diagnoses: Hypertension (high blood pressure), Diabetes (a chronic condition characterized by high blood sugar and Cerebrovascular Accident (when the blood supply to part of your brain is interrupted or severely reduced). An observation of Resident #6's bed sheets on 5/19/26 at 10:12 p.m. revealed the bed sheet had a large circular grey stain towards the foot of the bed. Resident #6 was groggy due to napping and stated he could not recall when staff last changed his sheets. An interview and observation with the Housekeeping Supervisor on 05/21/2026 at 8:49 a.m. revealed Shower room [ROOM NUMBER], by the front door, had a dirty floor with multiple brown marks, and two unidentified brown small objects on the shower floor. The Housekeeping Supervisor stated she did not know what the brown objects were. Observed a discarded wipe in the corner of the shower floor. The Housekeeping Supervisor stated the aides should have cleaned up after they used the shower room and it was the aides' responsibility to sanitize the showers after every shower. The Housekeeping Supervisor stated she checked the shower rooms twice per day and would clean them if they were visibly dirty. Observation of Shower room [ROOM NUMBER], in the secured unit, revealed a dirty floor with dirt marks and brownish stained tiles in the showers. The Housekeeping Supervisor stated Floor Tech A scrubbed the floors and tiles in the shower rooms every so often and housekeeping staff should have been mopping the floors in the shower rooms at least 2 times per day and as needed. Observation of Shower room [ROOM NUMBER], in the 200 hall, revealed a black wad of hair by the toilet and resident clothing hanging over the shower wall. The Housekeeper Supervisor stated the black wad was a hair ball and she proceeded to pick it up with a paper towel and throw it in the trash. The Housekeeping Supervisor was unable to identify whose clothing was hanging on the shower wall but stated it looked as though someone was about to shower and they were clean clothes. The shower in Shower room [ROOM NUMBER] was observed with two brown spots on the floor that were unidentifiable. Observation at 9:06 a.m. revealed a yellowish colored liquid on the floor in the 200 hall toward the linen closet. The Housekeeping Supervisor stated it was urine and asked (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	housekeeping staff to put up a wet floor sign. Observed two CNAs in the hall near the urine. The Housekeeping Supervisor walked the surveyor to the linen closet in the 200 hall and then went and told staff the urine needed to be cleaned. The Housekeeping Supervisor then put gloves on, got paper towels, cleaned up the urine with the paper towels, and instructed the housekeeper to sanitize the floor. Observed the housekeeper spraying sanitizer and mopping the floor. Observation of the Linen Closet in the 200 hall revealed 2 blankets, 1 fitted sheet and some hospital gowns. Observation of one folded blanket revealeda light brown stain that covered almost half of the blanket while folded. The fitted sheet was also folded and the top had 4 visible grey circular stains. The Housekeeping Supervisor stated the blanket and sheet were clean linens but stained. The Housekeeping Supervisor stated it was not acceptable to use stained linens on residents' beds and she had been replacing the stained linens as she saw them. The Housekeeping Supervisor stated since starting her position in April of 2026 she had been gradually replacing the linens because all the linens at the facility were in bad shape. The Housekeeping Supervisor stated she had ordered sheets and just received them this week and would order blankets this week. The Housekeeping Supervisor stated she had 3 types of staff: housekeeping, a floor tech and laundry. The Housekeeping Supervisor stated housekeeping staff were responsible for cleaning the rooms, hallways and surfaces at the facility. The Housekeeping Supervisor stated Floor Tech A was responsible for scrubbing shower room tiles and floors twice per week. The Housekeeping Supervisor stated Laundry Staff were responsible for washing linens and sorting linens, they also stock linens. The Housekeeping Supervisor stated it was the CNAs job to clean up urine or bodily fluids from the halls and rooms and maintain the cleanliness of the shower rooms after every shower. The Housekeeping Supervisor stated housekeeping staff also cleaned the shower rooms twice per day. The Housekeeping Supervisor stated the risk to the residents of having soiled floors in the hallway and dirty showers was the risk of cross contamination and spread of bacteria. The Housekeeping Supervisor stated staff should not have been using stained linens to make beds because it could make residents feel as though their sheets were dirty and it was a risk of cross contamination. The Housekeeping Supervisor stated the risk to the residents of having urine on the hallway floor was the residents could have slipped. An interview with Floor Tech A on 05/21/2026 at 10:25 a.m. revealed it was his responsibility to scrub the tiles and floors of the shower rooms on Tuesdays and Thursdays. Floor Tech A stated he was using tub and tile spray and used his scrubbing machine. Floor Tech A stated he last scrubbed them on Tuesday (05/19/26) and was waiting on the CNAs to finish the resident showers so he could scrub them today. Floor Tech A stated it was his responsibility to make sure the floors in the shower room were clean. Floor Tech A stated he made rounds all day every day throughout his shift to check the shower rooms for cleanliness. Floor Tech A stated CNAs were supposed to clean up after themselves after they showered residents and residents being showered in dirty showers could have made residents upset. An interview with CNA B on 05/21/2026 at 10:28 a.m. revealed she last changed Resident #6's sheets yesterday when she showered him. CNA B stated she used whatever sheets were available to them and some of the sheets had stains on them. CNA B stated she told Laundry Aide C about the stained sheets, but nothing was done because it was up to the Housekeeping Supervisor to order more sheets. CNA B stated stained sheets could affect the residents because it could make them feel dirty, unclean and they could have gotten upset. CNA B stated when she used the shower rooms before she left, she would put the towels in the dirty clothes, put away all the toiletries and clean the shower chair she used. CNA B would also ensure she cleaned up all the trash and if the resident had a bowel movement during the shower she was responsible for cleaning it up. CNA B stated it was CNAs responsibility to clean up bodily fluids, such as urine and feces and it was not housekeeping's job. CNA B stated anytime there were bodily fluids in the rooms, hallways or showers, housekeeping would spray something over it, the CNA would clean it up and then housekeeping would go after and sanitizer it. CNA B stated the risk of not cleaning bowel movement or urine correctly would have been residents could have slipped or it could have made them sick due to cross contamination and spread of bacteria. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with Laundry Aid C on 05/21/2026 at 10:43 a.m. revealed she documented on a daily log the numbers of linen she puts in the linen closets. Laundry Aid C stated they could not use stained linen, and it was her job to make sure stained linens were not sent out to the halls. Laundry Aid C could not state the reason the stained blanket and fitted sheets were in the linen closet because she typically put stained linens aside to show to the Housekeeping Supervisor before she threw it away. Laundry Aid C stated she would show the Housekeeping Supervisors the number of linens she was throwing away so the Housekeeping Supervisor would know how many to order. Laundry Aid C stated she received new sheets this week and she had to wash them before they used them, but noted they were flat sheets. Laundry Aid C stated they received a shipment of washed clothes and fitted sheets today. Laundry Aid C stated stained sheets could affect residents because residents could feel bad about stained sheets and may not want to lay on them. An interview with the Regional Compliance Nurse on 05/21/2026 at 11:17 a.m. revealed it was the responsibility of the nursing staff to clean up bowel movements, urine and bodily fluids from hallways, shower rooms and rooms. The Regional Compliance Nurse stated after the CNAs cleaned up urine/bowel movement, housekeeping would then disinfect the area. The Regional Compliance Nurse stated the risk to the resident of not having had the urine cleaned up immediately would have been the resident could have fallen; they could track it and transfer germs to others. The Regional Compliance Nurse stated it was CNAs' responsibility to clean up after themselves after every resident shower and if bowel movements or bodily fluids were in the shower the CNAs must clean them and notify housekeeping staff. CNA B stated it was the responsibility of housekeeping staff to clean the floors in the shower rooms. The Regional Compliance Nurse stated it was a dignity issue for residents to shower in a dirty shower and if showers were not cleaned after each resident shower it could cause the spread of bacteria and infection. The Regional Compliance Nurse stated staff should not have been using stained sheets on resident beds because it could have affected the resident's sense of dignity. An interview CNA D on 05/21/2026 at 1:19 p.m. revealed she changed residents' sheets if they were wet or soiled and after each shower. CNA D stated sometimes the clean bedding was stained and if it had a big stain, she would look for other linen if it was a small stain she would use it until other linen was available. CNA D stated she had not reported the stained linen to anyone. CNA D stated stained linen could affect the residents' happiness as they could feel down about having had stained sheets. CNA D stated after showers she made sure to clean whatever mess she made to include, removing dirty linen and spraying the area with disinfectant. CNA D stated if there was hair, trash or bowel movement she would clean it up and then notify housekeeping to sanitize. CNA D stated the risk of having a visibly dirty shower would have been a risk of contracting infections or the spread of bacteria. An interview with the Administrator on 05/21/2026 at 2:40 p.m. revealed the expectation of cleanliness for the shower rooms, included them being free of debris, mildew and should have always been clean. The Administrator stated it was the responsibility of the Housekeeping Supervisor to keep the showers clean and the responsibility of the CNAs to clean up urine from halls. The Housekeeping Supervisor and Laundry Aid C should have been keeping track of stained linen and whether they should have been replaced. The Administrator stated she had never told anyone not to order linens. The Administrator stated the Housekeeping Supervisor was new and when she started, she had told the Administrator they needed a lot of linen, and they had been ordering them. The Administrator stated it was not okay for staff to put stained linens on residents' beds. The Administrator stated the risk of having dirty linens and dirty showers would have been violation of their resident rights, it could have been an environmental hazard, cross contamination and infection control issues. Review of the facility's policy Resident Rights with no revision date reflected The resident has 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. A 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 must protect and promote the rights of the resident.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interviews and record review, the facility failed to store food in accordance with professional standards for the facility's only kitchen observed for food service safety.The facility failed to ensure food items in the facility refrigerators and dry storage were dated and labeled.These failures could place residents at risk for food borne illnesses and food contamination.Findings included:An observation on 05/19/26 at 10:23 AM in the facility's only kitchen revealed the two-door refrigerator contained previously opened two cans of mayonnaise, one can of mustard, one can of pickles that were not dated on the date opened. An observation of the three-door freezer revealed 6 packs of angel food cake in transparent plastic bags that were not dated with the expiration date or labeled with the name of the food item. An observation of the dry storage area revealed three cereal bags stored in transparent plastic bags were not dated with the expiration date and labeled with the name of the food items. An observation and interview on 05/19/2026 at 10:40 AM with the Director of Food and Nutrition revealed she had been working at the facility for 14 years. She walked along and looked at the food items which were not dated inside the two-door refrigerator, not labeled and dated in the three-door freezer and dry storage room. She stated she could not tell if those food items were good to use since they did not have a date reflecting when they were received/taken out of the original packing or opened. She stated the dietary staff followed the ?use by date chart' posted on the kitchen wall to identify and decide how long a food item was safe to use. She stated all dietary staff were responsible for dating and labeling food items once they were received, date when it was taken out of the original packaging, and when it was opened. She stated it was important for the food items to have those dates on them to easily identify if the food was good to use and to discard it by the use by date. She stated not dating, labeling food items would put all residents at risk for food borne illness. She stated all the dietary employees received training and in-services on safe food handling practices. She discarded the food items in the two-door refrigerator which were not dated. An interview on 05/20/2026 at 10:50 AM with the Dietary Cook, she stated she has been working at the facility for 7 years. She stated all the dietary staff were responsible for dating, labeling food items which were stored in the kitchen with date when it was received, and taken out of the original packaging. She stated not dating and labeling food items would put residents at risk for food borne illness. She stated she had received in-services on safe food handling. An interview on 05/20/2026 at 11:36 AM with the Dietary Staff, she stated all the dietary staff were responsible to date and label food items stored in the kitchen as when it was received/opened and taken out of the original packing. She stated not dating, labeling food items would put residents at risk for food borne illness. She stated she had received training on how to safely handle food as part of her hiring process. Review of the undated facility policy titled Food Storage and Supplies Procedure: .Open packages of food are stored in closed containers with covers or in sealed bags and dated as to when opened. Review of the Food and Drug Administration Food Code, dated 2022, reflected, .3-302.12 Food Storage Containers, Identified with Common Name of Food. Except for containers holding food that can be readily and unmistakably recognized such as dry pasta, working containers holding food, or food ingredients that are removed from their original packages for use in the food establishment, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the food 3-305.11 Food Storage.(B) .refrigerated, ready-to eat time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide the necessary services for residents who are unable to carry out activities of daily living to maintain good grooming and personal hygiene for 1 resident (Resident #9) of 5 residents reviewed for ADLs. The facility failed to ensure Resident #9 had his fingernails trimmed and cleaned on both hands on 05/19/2026. This failure could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections and skin breakdown, and a decreased quality of life.Record Review of Resident #9's Quarterly MDS assessment dated [DATE] as a [AGE] year-old male with initial admission date of 05/20/2016 to the facility. His pertinent diagnoses included: dementia (a decline in cognitive abilities, severe enough to interfere with daily life), legal blindness, and cognitive communication deficit. His BIMS score was 14, which indicated Resident #9' cognition was intact. Resident #9 needed maximal assistance with personal hygiene. Review of Resident #9 's Comprehensive Care Plan, revised 03/04/2023 reflected, Focus: [Resident #9] has ADL self-care performance deficit related to impaired mobility.Interventions: . [Resident #9[requires up to extensive assistance by one staff to perform activity. In an observation and interview on 05/19/2026 at 11:50 AM revealed Resident #9 was lying in his bed. The nails on both hands were approximately 0.3cm in length extending from the tip of his fingers. The nails were discolored, tan and had green brownish colored residue underside. Resident #9 stated he was blind and could not see his fingernails. He stated he did not like his fingernails long and dirty. In an interview on 05/19/26 at 12:04 PM, LVN H stated CNAs and nurses were responsible to clean and cut the residents' nails as needed. LVN H stated did not notice Resident #9's nails. She stated she would do it right then. She stated the risk would be infection control and injury. In an interview on 05/21/2026 at 10:42 AM, the Interim DON stated that her expectation was that ADL care be provided as needed. She stated that CNAs were responsible for providing nail care, including trimming fingernails, unless the resident had a diagnosis of diabetes. She stated that charge nurses were responsible for monitoring this care. The Interim DON stated that residents having long, dirty fingernails could result in skin breakdown and potential of infections. Record review of the facility policy Nail Care, not dated reflected . Nail management is the regular care of . fingernails to promote cleanliness, and skin integrity of tissues, to prevent infection, and injury from scratching by fingernails . It includes cleansing, trimming, smoothing . Nail care will be performed regularly and safely. The resident will be free from abnormal nail condition. The resident will be free from infection .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident for 1 (Medication Cart 100) of 3 medication carts reviewed for pharmacy services. The facility failed to ensure LVN E and LVN F responsible for Medication Cart 100, counted controlled drugs every shift change. This failure could place residents at risk of not having the medication available due to possible drug diversion. Record review and observation on 05/19/26 at 10:31 AM of Medication Cart 100, with LVN G revealed missing signatures for Off nurse for 05/09/2026, 05/12/2026, and 05/17/2026 (6:00 AM to 2:00 PM shift) of the narcotic count sheet. In an interview on 05/21/26 at 10:42 AM, the Interim DON stated she expected nurses to sign the narcotic count sheet at the beginning and at the end of their shift after they completed count with the incoming and off-going nurse. The Interim DON stated if the staff were not signing the narcotic count sheets, she was unable to prove they were counting. The Interim DON stated it was important to ensure a drug diversion did not occur. The Interim DON stated the ADONs would check the carts randomly. In an interview on 05/21/2026 at 11:27 AM, LVN F stated she should have signed the narcotic sheet after counting the narcotics, on 5/12/26 and 5/17/26 at the beginning and at the end of the shift. She stated maybe she got busy and did not go back to sign the count sheet. She stated she knew that she was supposed to sign immediately after the count was done. She stated the risk would be potential for drug diversion. In an interview on 05/21/26 at 11:30 AM, LVN E stated she should have signed the narcotic sheet after counting the narcotics on 05/09/26 at the beginning and at the end of the shift. LVN E stated she counted with the other nurse but she did not remember why she did not sign the count sheet. LVN E stated the failure could potentially cause a drug diversion. Review of the facility's policy Controlled Medication - Administration revised 4/6/26, reflected the following: . At each shift change, a physical inventory of all controlled medications is conducted by two licensed nursesand/or one nurse and a CMA, QMAP, Med Tech or equivalent as allowed by your State regulatory agency and isdocumented on an audit record. Alternatively, the shift change audit may be recorded on accountabilityrecord if there is a designated column for the audit .

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that residents received routine and 24-hour emergency dental services for one (Resident #44) of six residents reviewed for the provision of routine/emergency dental services.The facility failed to ensure Resident #44 received routine dental care.This failure could affect residents by placing them at risk of pain, weight loss, infection, difficulty eating and a decline in their quality of life due to unmet dental needs. Record Review of Resident #44's face sheet dated 05/21/26 revealed a [AGE] year-old female with admission date 01/08/26. Her diagnoses included: Dementia (severe decline in mental ability), Muscle Weakness (reduction in ability to exert force), Cognitive Communication Deficit (difficulty with communication caused by disrupted brain functions), Chronic Kidney Disease (damaged kidneys are unable to filter blood), and Alzheimer's Disease (progressive brain disorder).Record review of Resident #44's quarterly MDS assessment, dated 03/16/2026, reflected a BIMS score of 02, which indicated severe cognitive impairment. Section GG0130-Functional Abilities revealed partial/moderate assistance which indicated the helper does less than half the effort for oral hygiene. Review of Resident #44's Care Plan, revised 01/22/2022, reflected Resident #44 required extensive assistance by one staff with personal hygiene and oral care. Record review of Resident #44's electronic health record did not reflect dental services. During an observation and interview on 05/20/2026 at 8:55 a.m., Resident #44 revealed she wanted to go to the dentist. She stated she had not received dental services. She stated she didn't have issues with chewing or drinking. The observation of Resident #44's teeth revealed missing teeth at the top of the mouth and dark colored, missing teeth in the lower part of the mouth and dark gums.During an interview on 05/20/2026 at 11:00 a.m., the Social Worker stated she was responsible for making dental appointments. She stated there was a company that was contracted by the nursing facility for dental services and the dentist or dental hygienist would come to the facility. She stated routine dental appointments were scheduled yearly unless there was a referral for specialized dental services. She stated there wasn't documentation in PCC for routine dental services for Resident #44.During a follow up interview on 5/20/2026 at 1:40 p.m., the Social Worker stated according to the Dental Services policy, Resident #44 had Medicaid and didn't have a payer source for routine dental services. She stated if nursing brought to her attention an emergent dental need, she would try to find alternative sources for Resident #44 to receive dental services. She stated residents were not typically referred for routine dental services.During an interview on 5/21/2026 at 8:50 a.m., the Regional Compliance Nurse stated the Social Worker scheduled routine dental appointments and follow up appointments when needed. She stated routine dental appointments were important to ensure residents did not have pain, cavities, bacteria, and dignity issues. She stated residents' payer source was not a factor to determine if routine dental services were provided. She stated the IDT, which consisted of the Social Worker, nursing, and therapy, were responsible for ensuing residents received routine dental care.During an interview on 5/21/26 at 9:18 a.m., LVN I revealed she noticed Resident #44 had missing teeth. She stated dental issues were reported to the physician or nurse practitioner for an order for a dentist consultation. She stated once the consultation was received, it was given to the Social Worker for a dental appointment. She stated dental services were not relayed to the physician or nurse practitioner regarding Resident #44 since Resident #44 never complained of her teeth or mouth hurting and there were no issues with chewing. She stated she was unsure how often residents should have received routine dental care. She stated the risks of not maintaining routine dental appointments included tooth decay or infection of the gums,She stated the physician or nurse practitioner should have been informed of Resident #44's missing teeth.During an interview on 5/21/2026 at 2:27 p.m., the Administrator stated the Social Worker was responsible for making dental appointments. She stated per the dental services policy routine dental cleaning services were provided for residents upon (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	request or when there were issues pertaining to dental care. She stated the risk to residents who don't maintain routine dental services included gum disease, weight loss, and teeth loss. Record Review of the Dental Services facility policy revealed in part: The Director of Nursing Services, or his/her designee, is responsible for notifying Social Services of a resident's need for dental services. For Medicaid residents, the facility will provide all emergency dental services and those routine dental services to the extent covered under the Medicaid state plan. If any resident is unable to pay for dental services, the facility should attempt to find alternative funding sources or delivery systems so that the resident may receive the services needed to meet their dental needs and maintain his/her highest practicable level of well-being. This can include finding other providers of dental services, such as a dental school or the provision of dental hygiene services on site at a facility.

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	455835	A. Building B. Wing	05/21/2026

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

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain an infection control program designed to prevent the development and transmission of infection for 1 resident (Resident #77) of 3 residents observed for infection control. The facility failed to ensure CNA B changed gloves and completed hand hygiene during incontinent care for Resident #77 on 5/20/26. These failures could place residents at risk for infection and cross contamination of pathogens and illness. Record review of Resident #77's Quarterly MDS assessment dated [DATE] reflected Resident #77 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses included brain cancer, muscle weakness, and cognitive communication deficit. Resident #77's BIMS score of 6, which indicated Resident #77's cognition was severely impaired. The MDS assessment indicated Resident #77 required maximal assistance with toileting hygiene. Observation on 05/20/26 at 11:53 AM revealed CNA B entered Resident #77's room to provide incontinence care. She washed her hands and donned (put on) gloves, CNA B unfastened Resident #77's brief. She then provided peri-care to the resident, wiping across the resident's pubis bone and then down each groin. Without changing gloves CNA B helped the resident to roll on her side, she wiped the resident's buttock area with peri-wipes, front to back, she then removed the soiled brief and with soiled gloves, placed the clean brief under the resident. She removed and discarded the dirty gloves, she washed her hands and she donned clean gloves. She rolled the resident on her back onto the clean brief. Once finished, she fastened the resident's brief, she covered the resident and she lowered the resident's bed to a low position. She removed and discarded her gloves and washed her hands. In an interview on 05/20/26 at 12:05 PM, CNA B stated she should change her gloves and perform hand hygiene when she went from dirty to clean. She stated failing to provide proper care would expose the residents to infections. In an interview on 05/21/26 at 10:42 AM, the Interim DON stated she expected the staff to remove their gloves and sanitize their hands when going from dirty to clean. She stated CNAs were trained to perform hand hygiene between change of gloves. She stated failure to do so would potentially lead to cross-contamination and possible spread of infection. She stated the ADONs would do random rounds for monitoring. Record review of the facility policy titled Fundamentals of Infection Control Precautions not dated, reflected: . Failure to change gloves between resident contacts is an infection control hazard.