STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676247	A. Building B. Wing	02/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandy Lake Rehabilitation and Care Center	1410 E Sandy Lake Rd Coppell, TX 75019

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 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44405 Based on observations, interviews, and records review, the facility failed to provide appropriate assistive devices to residents who need them to maintain or improve their ability to eat or drink independently for 1 (Resident #1) of 3 residents reviewed for nutrition services. The facility failed to provide Resident #1 with an adaptive drinking aid (specialized cup) to assist with mobility issues and prevent accidental spills. On 02/03/24, CNA B served Resident #1 hot coffee in a 12-ounce insulated handle-free tumbler. Resident #1 did not have a grasp on the handle-free tumbler; coffee spilled and scalded the skin to [Resident #1's] right upper chest. This failure could place residents at risk for loss of self-worth and empowerment for independent drinking, which could lead to unplanned dehydration or more than minimal harm. Findings included: Record review of Resident #1's Face Sheet revealed the resident was a [AGE] year-old female, who admitted to the facility on [DATE] with the following diagnoses: Acute and chronic respiratory failure with hypoxia (having too little oxygen); Malignant neoplasm (cancerous tumor) of overlapping sites of bone and articular cartilage of unspecified limb; anxiety disorder; Depression; and other lack of coordination. The most recent re-entry date was 10/16/23. Record review of Resident #1's Quarterly MDS assessment, dated 01/18/24, revealed a BIMS Summary Score of 15 which suggested Resident #1 was cognitively intact. Resident #1's functional abilities required one-person physical assist with ADLs, two-person assist with transfers, and partial assistance (less than half the effort) to use suitable utensils to bring food and/or liquid to the mouth once the meal or drink is placed before the resident. Record review of Resident #1's active Physician Orders revealed: Start date: 02/02/23 Eating with assist of setup tray. Start date: 02/02/23 EQUIPMENT: Geri-chair (large, padded chairs with wheeled bases), Hoyer lift (a mobility tool used to transfer individuals with mobility challenges out of bed or between surfaces). (continued on next page)

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

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's comprehensive care plan, last care conference dated, 01/11/24, reflected the following Problem(s), Goals, and Approaches (interventions): - .contractures (a fixed tightening of muscle, tendons, ligaments, or skin) to bilateral (both sides) upper extremities (Start date: 02/08/24; Created: 02/08/24) - Hoyer lift for transfers (Start date: 02/08/24; Edited: 02/08/24) - [Resident #1] insisted to continue to use her personal cup which has no cup handles . (Start date: 02/05/24; Edited: 02/08/24) Resident #1's care plan goals reflected contractures would not worsen over the next 90 days; will be transferred safely and without injury over the next 90 days; and will make an informed choice about the benefits of care, options in care, and possible consequences/outcomes for resisting care. (Target Date: 05/08/24). Resident #1's care plan approach(es) created: 02/08/24, revealed to assess areas contractures, physician notification, OT/PT evaluation, use of devices, splints, appliances as tolerated; two-person assist to transfer with Hoyer lift; and [Resident #1] to use cup with handles (Created: 02/06/24). Record review of Resident #1's Progress notes revealed: 01/24/24 at 1:19 PM: Dietary note. The Dietician wrote, . remains within stable weight range; receiving house diet; preferences being honored as appropriate; assisted at meals . 02/03/24 at 1:13 PM: Nurse Note. LVN A wrote, [Resident #1] reported . she spilt coffee on herself, [LVN A] immediately went to get and apply ice pack after assessing, noted redness . 02/04/24 at 2:11 AM: Nurse Note. LVN D wrote, Monitoring continued for burn to right chest. Redness present. reports 3/10 pain. Ice pack applied. 02/04/24 at 10:23 AM: Nurse Note. LVN A wrote, [Resident #1] insisted to continue to use her personal cup which is not safe as the cup is handless. MDS will put in a care plan for resident. Nurse educated resident on the use of facility provided cup. Resident refuse. AM will follow up with MDS on Monday [02/05/24]. 02/05/24 at 4:50 AM: RN E wrote, Continues Monitoring for burn to right chest Day #3. Redness is still present. Denies any pain During an interview on 02/08/24 at 2:45 PM, the M-DON stated that RN C notified her that Resident #1 spilled coffee on herself that caused redness to her chest. The M-DON stated that she spoke with LVN A and inquired about the cause of the spill, actions taken, and if the MD and RP were notified. The M-DON said that she instructed RN C to initiate an in-service on the topic of serving hot beverages. The M-DON said that she went to the SNF the next day (Sunday morning [02/04/24]) to oversee in-service participation and to conduct skin sweeps to ensure other residents were not affected by hot beverage spills. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 02/08/24 at 3:30 PM, Resident #1 was sitting up in bed, head of bed raised approximately 45 degrees. Resident #1's right and left hands/wrists appeared claw-like, 1 or more fingers were (contracted) or pulled in toward the palms. The bedside table was placed across the bed over Resident #1's lower body. Personal belongings, a plastic handle-free tumbler with a lid and straight straw, and a cell phone were on table within the resident's reach. A touchpad call light was to Resident #1's right side and within reach. During an interview, Resident #1 said that a male aide [later identified as CNA B] brought her coffee per request. Resident #1 said when she requested coffee, the staff would normally mix cream and sugar in the coffee firse in a facility dining cup, then poured it in a small plastic handle-free cup with a lid and straight plastic straw for her to drink from. Resident #1 said that CNA B took an insulated handle-free tumbler she had at her bedside to fill with coffee. Resident #1 said that a family member gave her the insulated tumbler as a gift to keep her coffee warm to drink. [Resident #1 pointed to the dresser where the insulated handle-free tumbler was placed and instructed not to use]. Resident #1 said that CNA B returned with the handle-free insulated tumbler and placed it in front of her on the bedside table. Resident #1 said she reached for the insulated handle-free tumbler to take a sip coffee, but it was difficult to grasp, it slid from her grip, and the coffee spilled on her chest. Resident #1 denied that the incident happened before and did not want to make a big deal or get anyone in trouble. Resident #1 said that it was an accident. Resident #1 was asked to press the call light touchpad for assistance. Resident #1 was able to do so without difficulty. Resident #1 said that the facility did not provide cups with handles or suggested that she should not use her personal cups. Resident #1 said that there was no special equipment provided when she eats or drinks. During an interview and observation on 02/08/24 at 3:45 PM, CNA D entered the room to answer the call light. CNA D said that she was unaware of the incident, but it made sense why an in-service was conducted over the weekend about serving hot beverages. CNA D demonstrated how she assisted Resident #1 with drinking. CNA D assisted Resident #1 to a comfortable position and raised the head of the bed to a 60-degree upright position. CNA D placed Resident #1's plastic handle-free tumbler with a lid and straight straw at the edge of the bedside table. Resident #1 reached and placed her wrists on opposite sides of the handle-free tumbler and pulled toward her to drink from the straw. CNA D aided with placing the cup back on the table. CNA D presented an 8-oz plastic handle-free cup with lid and straight straw that staff filled with coffee when served to Resident #1. CNA D said that the 8-oz plastic handle-free cup with lid and straight straw was used for coffee and the 12-ounce plastic handle-free tumbler was used for water and soda. CNA D said that Resident #1 had two 12-ounce handle-free tumblers. CNA D said that she was unaware of any special equipment available for Resident #1 to assist with eating or drinking. CNA D said that she assisted Resident #1 with eating unless finger foods or sandwiches were served that Resident #1 could eat without assistance. During an observation on 02/08/24 at 4:00 PM, CNA D assisted Resident #1 with raising her blouse for visual inspection of the right upper chest where the hot coffee spilled (on 02/03/24). Inspection of Resident #1's right upper chest revealed a pale, reddish pink discoloration at the identified burn area. The site looked like a minor superficial burn injury, or scald injury caused by a wet agent such as hot water or steam. The skin was intact, and no blisters were noted. Resident #1 denied pain or discomfort. On 02/08/24 at 4:30 PM, an outbound call was placed to CNA B. The call was unanswered and unable to leave a message. The M-DOM said that CNA B was scheduled to work on Saturday, 02/10/24. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/08/24 at 4:40 PM, the Dietary Manager was not present. The NFA stated the Dietary Manager was unavailable due to personal reasons. During an interview on 02/10/24 at 12:22 PM, RN C, the weekend supervisor said that LVN A notified that Resident #1 had spilled coffee on herself and the MD had already been notified. RN C said she went to assess Resident #1. RN C said that she noted some redness at the right upper chest, but no blistering. RN C said she notified the M-DON and then sent an email to HHS as a self-report incident. During a phone interview on 02/10/24 at 12:34 PM, the DOR stated that she and the other therapists (PT/OT/ST) were contracted by the facility. The DOR said that she screened Resident #1 after the incident. When asked to clarify, the DOR said that she screened the progress note entered by LVN A that Resident #1 spilled her coffee on herself and determined the plan of care was in place. The DOR stated that she was responsible for assessing residents for mobility issues and particular adaptive equipment needs. The DOR indicated that Resident #1 had been evaluated by PT and OT in the past. The DOR stated Resident #1 was at her highest level of ADL function without adaptive aids or assistive equipment. The DOR said that Resident #1 was re-evaluated by OT the following day (02/04/24) after the incident. The DOR provided the name and phone number to reach the OT that re-evaluated Resident #1 for mobility issues and assistive needs. During a phone interview on 02/10/24 at 1:19 PM, the OT stated she was consulted to follow up on a burn and evaluate Resident #1 for ADL mobility and adaptive equipment needs. The OT stated she saw Resident #1 the same day she was consulted (on 02/09/24). The OT stated she immediately had a concern for Resident #1's safety and the staff's safety awareness. The OT stated that Resident #1 could benefit from adaptive equipment for eating and drinking. The OT said when she discussed her findings, the DOR replied that Resident #1 had a long straw for assistance. The OT indicated that the long straw was ineffective because it was not flexible. The OT said that she would need to research the appropriate eating and drinking aide for Resident #1, locate a vendor, obtain an order from the physician for the facility to order the selected adaptive equipment for safety, nutritional intake, and functional eating skills in use of utensils, cups, and bowls for independence. The OT stated that the resident and staff would require training in use and assistance with adaptive equipment. Record review of OT progress notes revealed an OT Evaluation and Plan of Treatment, dated 10/17/23, was completed by the DOR. It did not reflect recommendations for adaptive eating equipment and utensils and revealed: Patient Goals: [Resident #1] to be able to be up in wheelchair. Potential for Achieving Rehab Goals: [Resident #1] demonstrates good rehab potential as evidenced by motivated to participate. Current Referral Reason for Referral: [Resident #1] exhibits new onset of compromised physical exertion level during activity, decrease in functional mobility, decrease in range of motion (ROM), decrease in strength, decreased coordination, decreased neuromotor control, falls/fall risk, functional limitation with ambulation, increased need for assistance from others, reduced dynamic balance, reduced static balance and reduced ADL participation. Review of the most recent OT Evaluation and Plan of Treatment dated 02/09/24 (after the 10/17/23 OT progress note) indicated: (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Patient Goals: [Resident #1] able to use adaptive equipment safely to decrease burden of care. Potential for Achieving Rehab Goals: [Resident #1] demonstrates good rehab potential as evidenced by ability to follow multi-step directions and motivated to participate. Current Referral Reason for Referral: [Resident #1] referred to OT due to decline in strength, ability to perform functional activities without physical assistance, ADL participation, coordination, range of motion (ROM) and postural alignment. During an interview on 02/10/24 at 1:38 PM, LVN A said that she worked a double shift (6:00 AM-2:00 PM and 2:00 PM-10:00 PM) on Saturday, 02/03/24. LVN A described Resident #1 as having bilateral contracted hands, could feed self, but needed intermittent assistance and stated, Resident #1 wants to feed herself. LVN A said on 02/03/24, in the afternoon, she saw Resident #1's call light on (around lunch time). LVN A said when she entered Resident #1's room to answer the call light, Resident #1 informed her that she spilled her coffee, but [Resident #1] said it was not a big deal. LVN A said that Resident #1 kept saying that she did not want to make it an issue. LVN A said she asked what happened and Resident #1 said that [CNA B] had helped her change her top. LVN A said she assessed Resident #1's right upper chest, right above her breast, and noted some redness. LVN A said she ran to get some ice and placed it on the site. LVN A said she called the MD and the MD said to continue to monitor. LVN A said she located CNA B and had a verbal 1:1 about notifying the nurse about any change or possible harm to a resident regardless how small the CNA may think the concern was. LVN A said an in-service was initiated by RN C on the topic of serving hot beverages. An outbound call was placed to CNA B on 02/10/24 at 3:00 PM. The call was unanswered and not returned before exit conference. Review of the facility's policy titled, Assistance with meals, dated March 2022, reflected: Residents shall receive assistance with meals in a manner that meets the individual needs of each resident. Residents who may benefit from assistive devices: 1. Adaptive devices (special eating equipment and utensils) will be provided for residents who need or request them. These may include devices such as silverware with enlarged/padded handles, plate guards, and/or specialized cups. 2. Assistance will be provided to ensure than residents can use and benefit from special eating equipment and utensils. 3. Residents may choose not to use adaptive devices.