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	07/25/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055 Based on observations, interviews, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life for one (Resident #53) of 5 residents reviewed for dignity. The facility failed to treat Resident #53 with dignity and promote enhancement of his quality of life when the resident was not provided a privacy bag for his catheter bag. This failure placed residents at risk of not having their right to a dignified existence maintained. Findings included: Review of Resident #53's Face Sheet, dated 07/23/2024, reflected resident was a [AGE] year-old male admitted on [DATE]. Resident #53 was diagnosed with neuromuscular dysfunction of bladder (the muscles and nerves that control the bladder do not work properly due to illness). Review of Resident #53's Quarterly MDS Assessment, dated 06/25/2024, reflected Resident #53 was cognitively intact with a BIMS score of 15. The Quarterly MDS Assessment indicated that the resident had an indwelling catheter. Review of Resident #53's Comprehensive Care Plan, dated 06/05/2024, reflected Resident #53 had an indwelling catheter and one of the interventions was assist/provide catheter care every shift. Review of Resident #53's Physician Order, dated 05/30/2024, reflected Continuous indwelling foley catheter, 16 French (French: unit used to indicate the size of the catheter) for neurogenic bladder (the normal bladder function is disrupted due to nerve damage). Review of Resident #53's Physician Order, dated 05/30/2024, reflected Privacy bag in place, every shift. Place Foley (device used to help drain urine from bladder) bag in privacy bag. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview with Resident #53 on 07/23/2023 at 9:18 AM revealed Resident #53 was on his bed, awake. Resident #53 had a catheter bag hanging at the railings below the bed. The urine inside catheter bag was observed visible upon entrance to the room. The catheter bag did not have a privacy bag. Resident #53 stated he had the catheter for the longest time due to a bladder dysfunction. Resident #53 said he was not aware his catheter bag was exposed. Observation on 07/23/2024 at 10:49 AM revealed Resident #53's catheter bag still did not have a privacy bag. The content of the catheter bag was still visible upon entrance to the room. In an interview with LVN A on 07/23/2024 at 11:21 AM, LVN A confirmed Resident #53's catheter bag did not have a privacy bag. LVN A said there should be a privacy bag for the urine drainage bag so that it will not be visible to other residents or visitors. She said without the privacy bag, the resident might be embarrassed, humiliated, or uncomfortable going out of the room. She said she did not notice the urine drainage bag was exposed. She said she would get a privacy bag for Resident #53's catheter. She said she was responsible in making sure the catheter bag had a privacy bag. In an interview with CNA B on 07/23/2024 at 11:36 AM, CNA B stated she just emptied Resident #53's catheter bag and put it inside a privacy bag as instructed by LVN A. She said she emptied the catheter bag earlier but forgot to put a privacy bag on the catheter bag. She said there should be a privacy bag whether the resident was inside the room or outside the room to prevent embarrassment. In an interview with the DON on 07/24/2023 at 4:00 PM, the DON stated the catheter bag should have been placed inside a privacy bag to avoid embarrassment and humiliation. The DON said all the residents had the right for a dignified existence and not having a privacy bag was not one of them. She said all the staff, including her, were responsible in providing dignity to the residents with catheter. The DON said the expectation was for the staff to make sure the catheter bag had a privacy bag when the resident was on the bed or in the wheelchair. She concluded that she would continually remind the staff the importance of dignity and privacy for residents with catheter through an in-service. In an interview with ADON E on 07/24/2024 at 5:03 PM, ADON E stated all the residents should be treated with dignity. She said caring with dignity could be pulling the privacy curtain while providing care or making sure the resident's profile could not be read by other residents or visitors. She said, for a resident with catheter, there should be privacy bag to maintain dignity. She added without the privacy bag, the resident might prefer to stay inside the room so that other residents would not see he had a catheter. She said the expectation was for the staff to be mindful of the feelings of the residents with catheter. She said they would do an in-service pertaining to maintaining the residents' dignity. In an interview with the Administrator on 07/24/2024 at 5:11 PM, the Administrator stated his expectation was for all the staff to provide dignity to all the residents. He said a catheter bag without a privacy bag was a dignity issue because if the urine bag was visible, it could cause embarrassment. He said he would coordinate with the clinicians concerning the privacy bag. Review of facility policy, Resident Rights Leadership Policies and Procedures revised 11/1/2017 revealed Policy: The facility staff will provide the patient/resident with the right to an environment that preserves dignity and contributes to a positive self-image. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy, Catheter Care revealed Purpose: To promote hygiene, comfort, and decrease the risk of infection for a resident with an indwelling urinary catheter . Procedure . 14. Cover the drainage bag with a privacy bag to maintain dignity.

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055 Based on interviews and record reviews the facility failed to notify the physician of an accident that resulted in an injury and required the physician intervention for 1 (Residents #25) of 1 resident reviewed for notification of changes. The Director of Therapy failed to notify Resident #25's physician when the resident injured her left leg on 04/02/24 while being transported in her wheelchair without footrests. Resident #25 sustained a fracture which was not discovered until 04/06/24 when the NP was notified and ordered an x-ray. This failure placed the resident at risk of not receiving immediate medical attention and at risk of further damage to her leg. The noncompliance was identified as past noncompliance (PNC) The IJ began on 04/02/24 and ended on 04/08/24. The facility had corrected the noncompliance before the state's investigation began. Findings included: Record review of Resident #25's face sheet, dated 07/23/2024, revealed she was a [AGE] year-old female admitted on [DATE]. Relevant diagnoses included diabetes (high blood sugar) and hemiplegia. Record review of Resident #25's Quarterly Minimum Data Set (MDS) dated [DATE] revealed, she had a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact) and for ADL care it stated, for transfers, toileting, and bathing, the resident required moderate assistance. Record review of Resident #25's progress notes from 04/02/24 thru 04/05/24, revealed no indication of the resident complaining of pain. Pain assessments were completed, and all documentation indicated Resident Denies of Pain or Discomfort for This Shift. Record review of Resident #25's progress notes on 04/06/24 indicated that the resident had complained of pain in her left leg to LPN M, who completed a pain assessment, and notified the Nurse Practitioner who ordered an x-ray be completed of Resident #25's left leg. Further review of Resident #25's progress notes entered by LPN M dated 04/06/24 at 6:53 PM, revealed Xray diagnostic company called and reported that x-ray is positive for Left knee FX, NP notified and gave order to send out to ER, Daughter family member, Resident notified, ADON, DON and Administrator notified. PRN pain medication administered. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 07/23/24 at 01:57 PM, Resident #25 stated the Director of Therapy had caused her to break her leg. She stated the on 04/02/24 the DOT was pushing her back to her room from the dining room. She stated that on her way back to her room, her sneakers had gripped the floor, and it caused her left leg to get caught under her wheelchair. She stated the accident caused her to break her knee. She stated that she had to lay in bed for 8 weeks until she was able to sit in her wheelchair and begin moving again. She stated the facility had terminated the DOT for injuring her. She stated she was in pain when the accident occurred, and she had complained about her leg hurting her unto the weekend nurse on 04/06/24. She contacted the physician, and the physician advised the nurse to send the resident out for an x-ray, which was when she was advised that she had fractured her leg. She stated she had no concerns with staff and felt safe at the facility. In an interview on 07/24/24 at 11:31 AM, the Physical Therapist stated she had been at the facility for over 2 years. She stated she was familiar with Resident #25, but she was not at the facility when the incident occurred on 04/02/24. She stated she heard the resident was being wheeled by the Occupational Therapist Assistant, who was also the DOT, from the dining room and for some reason the DOT failed to install the footrest for the resident. She stated she heard that the resident's leg had gotten caught under the wheelchair and she injured her leg. She stated the DOT did not report the incident until the resident had complained about the injury. She stated because of this, she was terminated. The PT stated staff was in-serviced on reporting any injuries or changes in condition on 04/08/24. She stated the risk of not notifying the resident's physician could result in the resident going untreated for a severe injury. In an interview on 07/25/24 at 09:45 AM, the Regional Director of Operations, stated she had been the director since January 2024 and the Area Director prior to her new role. She stated the resident had complained of pain throughout the weekend (04/06/24 and 04/07/24), they found out about the resident being injured, and it was not reported. They stated they immediately placed the Director of Therapy on leave and removed her from all resident responsibility. She stated the team was in-serviced on transporting residents in wheelchairs, using the footrest, and reporting incidents. She stated the resident had increased pain over the weekend and it was discussed during the morning meeting on 04/08/24. The DOT did not report the incident that occurred on 04/02/24 until the morning meeting on 04/08/24. The Administrator immediately suspended her, and ultimately terminated her employment. She stated the risk of the Director of Therapy not reporting the incident until 04/08/24 could have resulted in the resident experiencing a severe injury and having pain. In an interview on 07/25/24 at 09:53 AM, RN K stated she had been at the facility for almost two years. She stated that she managed the 100-Hall, and she was familiar with Resident #25. She stated the resident only complained about her normal pain and she was not aware of any new pain the resident was having. She stated the resident did not like getting out of bed, only for special events, and the resident council meetings. She stated she was made aware of the resident's injury when she returned to work on 04/08/24. She acknowledged completing an in-service on reporting changes in condition and notifying the physician. She stated the risk of not reporting the pain the resident had could result in serious injury like a broken bone. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 07/25/24 at 10:05 AM, the ADON stated she was familiar with the incident regarding Resident #25. She stated she heard the DOT was taking the resident back to her room and she had failed to put the footrests on the resident's wheelchair and the resident injured her leg. She stated she had not heard the resident complaining of pain until 04/06/24, and the weekend nurse contacted the physician, who referred her to the hospital for x-rays. She stated she had heard a couple of days later of what happened after speaking with the resident. She stated the CNA was supposed to notify the nurse of any pain a resident was having so that the nurse can follow up with the resident to assess what was wrong. She stated she nor the nursing staff received any reports of the resident having any new pains. She stated the resident rarely got out of her bed and she had not gotten out of bed that week (04/03/24 to 04/05/24). She stated the risk of not reporting the incident could result in the resident experiencing a severe injury and having pain untreated. In an interview on 07/25/24 at 10:25 AM, the Administrator stated that he knew of the incidents that occurred with Resident #25, and he stated it should have been reported sooner, which was why he had suspended and later terminated the DOT for being neglectful. He stated he had met with all staff and had in-serviced them on reporting injuries, fall protocols, and proper wheelchair transport and positioning on 04/08/24. He stated that he decided to terminate the DOT because of her not reporting the incident and her being neglectful in not using the resident footrest. He stated he had made several attempts to contact the DOT to interview her, but she had not returned his call. He stated the risk for not using the footrest and not reporting the incident once the incident had occurred was not good for the resident because she had a serious injury that went unnoticed for several days. In an interview on 07/25/24 at 03:10 PM, the Nurse Practitioner stated he was advised of the incident that occurred with the resident on 04/06/24. He stated when he was advised that the resident was complaining of pain in her leg, he immediately had her sent out for x-rays. He stated he was made aware that there was an incident involving a wheelchair and she had twisted her left leg. He stated the resident sustained a fracture below her knee, but it did not result in her needing a cast on her leg but instead a leg immobilizer. He stated the resident rarely left her bed and could have had pain when readjusting herself in bed. Attempts were made to contact the DOT for an interview on 07/24/24 at 12:00 PM, on 07/25/23 at 11:00 AM, and on 08/06/24. Each time the phone went directly to voicemail. Record review of the facility policy referencing PHYSICIAN AND OTHER COMMUNICATION/CHANGE IN CONDITION dated 05/05/23, To improve communication between physicians and nursing staff to promote optimal patient/resident care, provide nursing staff with guidelines for making decisions regarding appropriate and timely notification of medical staff regarding changes in a patient's/resident's condition, and provide guidance for the notification of patients/residents and their responsible party regarding changes in condition. The facility took the following actions to correct the noncompliance prior to the investigation: The facility re-educated the staff on Policy and procedure for Wheelchair transport and positioning, Patient Safety and Incident Reporting; and Fall Protocol. The facility conducted an AD Hoc Quality Assurance Meeting and terminated the previous Director of Therapy prior to the beginning of the HHSC investigation on 07/22/24. The Staff confirmed when interviewed they were adequately trained to report immediately to the Administrator, if they heard or suspected abuse, neglect or exploitation

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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** 45055 Based on observations, interviews, and record review the facility failed to provide a safe, clean, comfortable, and homelike environment including but not limited to receiving treatment and supports for daily living safely for areas in the facility for 12 (room [ROOM NUMBER], #106, #107, #108, #109, #110, #112, #113, #115, #116, #117, and #120) of 12 resident rooms and the facility common areas observed for cleanliness and sanitization. The facility failed to ensure that Resident Room ##105, #106, #107, #108, #109, #110, #112, #113, #115, #116, #117, and #120 were thoroughly cleaned, and sanitized. The facility failed to ensure the handrails on the hallways of the facility, were thoroughly cleaned, and sanitized. These deficient practices could place residents at risk of living in an unclean and unsanitary environment which could lead to a decreased quality of life. Findings included: An observation on 07/23/24 at 10:45 AM of the facility hallways revealed areas of the halls where the handrails had long streaks of a dark thick brownish stain going down the length of the handrails. An observation on 07/23/24 at 10:56 AM of Resident room [ROOM NUMBER] reflected a vent in the resident bathroom shower area had dust and dirt debris. The corners of the floor in the resident bathroom had dirt particles and built-up dirt stains. The shower floor had dark stains in the corners. There was a dark stain circling the toilet. An air vent on the wall had dark stains and dust all over it. The air conditioning unit in the room had dust and dirt on the outside of the unit and in the vents. The air filter had thick dirt and dust in it. An observation on 07/23/24 at 11:01 AM of Resident room [ROOM NUMBER] reflected the corners and along the walls of the floor in the resident bathroom had dirt particles and built-up dirt stains. The shower floor had dark stains in the corners. The air conditioning unit in the room had dust and dirt on the outside of the unit and in the vents. The air filter had thick dirt and dust in it. An observation on 07/23/24 at 11:08 AM of Resident room [ROOM NUMBER] reflected the corners and along the walls of the floor in the resident bathroom had dirt particles and built-up dirt stains. The shower floor had dark stains in the corners. An observation on 07/23/24 at 11:13 AM of Resident room [ROOM NUMBER] reflected the shower curtain having white stains along the lower portion of the curtain. The shower floor had dark stains in the corners. An observation on 07/23/24 at 11:19 AM of Resident room [ROOM NUMBER] reflected the resident bathroom floor had dirt and dark stains in the corners, along the walls of the floor, and behind the toilet in the resident bathroom had dirt particles and built-up dirt stains. (continued on next page)

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	676247	A. Building B. Wing	07/25/2024

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 07/23/24 at 11:27 AM of Resident room [ROOM NUMBER] reflected the air conditioning unit in the room had dust and dirt on the outside of the unit and in the vents. The air filter had thick dirt and dust in it. An observation on 07/23/24 at 11:27 AM of Resident room [ROOM NUMBER] reflected the air conditioning unit in the room had dust and dirt on the outside of the unit and in the vents. The handrails in the resident's bathroom had dark rust along the edges and the rails had black speckles peppered all over them. An observation on 07/23/24 at 11:48 AM of Resident room [ROOM NUMBER] reflected the corners and along the walls of the floor in the resident bathroom had dirt particles and built-up dirt stains. The shower floor had dark stains in the corners. The air conditioning unit in the room had dust and dirt on the outside of the unit and in the vents. The air filter had thick dirt and dust in it. An observation on 07/23/24 at 11:53 AM of Resident room [ROOM NUMBER] reflected the corners and along the walls of the floor in the resident bathroom had dirt particles and built-up dirt stains. The shower floor had dark stains in the corners. The air conditioning unit in the room had dust and dirt on the outside of the unit and in the vents. The air filter had thick dirt and dust in it. An observation on 07/23/24 at 11:55 AM of Resident room [ROOM NUMBER] reflected the air conditioning unit in the room had dust and dirt on the outside of the unit and in the vents. An observation on 07/23/24 at 12:02 PM of Resident room [ROOM NUMBER] reflected the air conditioning unit in the room had dust and dirt on the outside of the unit and in the vents. The air filter had thick dirt and dust in it. A white air vent on the wall had light brownish stains all over it. An observation on 07/23/24 at 11:27 AM of Resident room [ROOM NUMBER] reflected the air conditioning unit in the room had dust and dirt on the outside of the unit and in the vents. The air filter had thick dirt and dust in it. A white air vent on the wall had light brownish stains all over it. The corners and along the walls of the floor in the resident bathroom had dirt particles and built-up dirt stains. The shower floor had dark stains in the corners. In an interview on 07/25/24 at 12:13 PM, Housekeeping S stated she had been at the facility for two weeks. She stated she was trained by shadowing the housekeeping for the 200 Hall. She stated they mop the floor, clean the bathroom, and wipe down the mirrors. She stated they were supposed to clean the air conditioning units in the resident rooms. She stated they [NAME] supposed to clean the air filters. She was shown pictures of the concerns observed in Resident rooms #105, #106, #107, #108, #109, #110, #112, #113, #115, #116, #117, and #120. She stated she was not sure who cleaned the handrails in the hallways. She stated they deep cleaned 2 to 3 rooms a day and she was usually done by the end of the week. She stated laundry cleaned the curtains. She stated if the resident rooms [NAME] not thoroughly cleaned the residents could get sick, bacteria could spread, and the residents would not want to take a shower in a dirty shower. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 07/25/24 at 12:30 PM, the Housekeeping Supervisor stated staff were supposed to clean the entire rooms, including the bathrooms, sweep and mop floor, clean the air conditioning units, and wipe the furniture down. He was shown pictures of the concerns observed in Resident rooms #105, #106, #107, #108, #109, #110, #112, #113, #115, #116, #117, and #120. He stated the resident rooms, handrails, and showers were to be cleaned daily. He stated there was no excuse why those areas were not clean. He stated he tried to inspect the rooms. He stated he was responsible for ensuring the resident shower curtains were cleaned. He stated he did not have a schedule to have them cleaned. He stated the risk of the issues not being resolved could result in residents getting sick and the spread of bacteria. In an interview on 07/25/24 at 12:40 PM, the Administrator stated he had he was working very closely with his housekeeping and maintenance staff to improve the cleanliness and the physical appearance of the facility. He was shown some pictures of the concerns observed in rooms #105, #106, #107, #108, #109, #110, #112, #113, #115, #116, #117, and #120. He was also shown pictures of the dirty handrails. He stated his expectation for his housekeeping supervisor was to ensure that they were thoroughly cleaning rooms and the commons areas of the facility. He stated key leadership were supposed to complete Angel rounds, which consisted of key leadership visiting the residents daily to ensure that they were doing well. He stated that they were not doing this on a consistent basis, but he would re-enforce it. He stated the risk of not thoroughly cleaning resident rooms and common areas of the facility, could result in contamination. Review of the facility's policy on Safe/Comfortable/Homelike Environment (Revised 2022) reflected Housekeeping and Maintenance services include the cleaning, sanitization, and care for rooms and common areas of the facility to ensure that the facility is safe for all who reside, work, and visit.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 45055 Based on interviews and record reviews the facility failed to ensure the resident received adequate supervision and assistance devices to prevent accidents for 1 (Residents #25) of 1 resident reviewed for accidents and hazards. On 04/02/24, Director of Therapy failed to utilize Resident #25's footrest when transporting her which resulted in a fracture to her left leg. This failure placed the resident at risk of further injury due to improper use of equipment. The noncompliance was identified as past noncompliance (PNC) The IJ began on 04/02/24 and ended on 04/08/24. The facility had corrected the noncompliance before the state's investigation began. Findings included: Record review of Resident #25's face sheet, dated 07/23/2024, revealed she was a [AGE] year-old female admitted on [DATE]. Relevant diagnoses included diabetes (high blood sugar) and hemiplegia. Record review of Resident #25's Quarterly Minimum Data Set (MDS) dated [DATE] revealed, she had a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact) and for ADL care it stated, for transfers, toileting, and bathing, the resident required moderate assistance. Record review of Resident #25's progress notes from 04/02/24 thru 04/05/24, revealed no indication of the resident complaining of pain. Pain assessments were completed, and all documentation indicated Resident Denies of Pain or Discomfort for This Shift. Record review of Resident #25's progress notes on 04/06/24 indicated that the resident had complained of pain in her left leg to LPN M, who completed a pain assessment, and notified the Nurse Practitioner who ordered an x-ray be completed of Resident #25's left leg. Further review of Resident #25's progress notes entered by LPN M dated 04/06/24 at 6:53 PM, revealed Xray diagnostic company called and reported that x-ray is positive for Left knee FX, NP notified and gave order to send out to ER, Daughter family member, Resident notified, ADON, DON and Administrator notified. PRN pain medication administered. In an interview on 07/23/24 at 01:57 PM, Resident #25 stated the Director of Therapy had caused her to break her leg. She stated the on 04/02/24 the DOT was pushing her back to her room from the dining room. She stated that on her way back to her room, her sneakers had gripped the floor, and it caused her left leg to get caught under her wheelchair. She stated the accident caused her to break her knee. She stated that she had to lay in bed for 8 weeks until she was able to sit in her wheelchair and begin moving again. She stated the facility had terminated the DOT for injuring her. She stated she was in pain when the accident occurred, and she had complained about her leg hurting her unto the weekend nurse on 04/06/24. She contacted the physician, and the physician advised the nurse to send the resident out for an x-ray, which was when she was advised that she had fractured her leg. She stated she had no concerns with staff and felt safe at the facility. (continued on next page)

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	07/25/2024

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 07/24/24 at 11:31 AM, the Physical Therapist stated she had been at the facility for over 2 years. She stated she was familiar with Resident #25, but she was not at the facility when the incident occurred on 04/02/24. She stated she heard the resident was being wheeled by the Occupational Therapist Assistant, who was also the DOT, from the dining room and for some reason the DOT failed to install the footrest for the resident. She stated she heard that the resident's leg had gotten caught under the wheelchair and she injured her leg. She stated the DOT did not report the incident until the resident had complained about the injury. She stated because of this, she was terminated. The PT stated staff was in-serviced on reporting any injuries or changes in condition on 04/08/24. She stated the risk of not notifying the resident's physician could result in the resident going untreated for a severe injury. In an interview on 07/25/24 at 09:45 AM, the Regional Director of Operations, stated she had been the director since January 2024 and the Area Director prior to her new role. She stated the resident had complained of pain throughout the weekend (04/06/24 and 04/07/24), they found out about the resident being injured, and it was not reported. They stated they immediately placed the Director of Therapy on leave and removed her from all resident responsibility. She stated the team was in-serviced on transporting residents in wheelchairs, using the footrest, and reporting incidents. She stated the resident had increased pain over the weekend and it was discussed during the morning meeting on 04/08/24. The DOT did not report the incident that occurred on 04/02/24 until the morning meeting on 04/08/24. The Administrator immediately suspended her, and ultimately terminated her employment. She stated the risk of the Director of Therapy not reporting the incident until 04/08/24 could have resulted in the resident experiencing a severe injury and having pain. In an interview on 07/25/24 at 09:53 AM, RN K stated she had been at the facility for almost two years. She stated that she managed the 100-Hall, and she was familiar with Resident #25. She stated the resident only complained about her normal pain and she was not aware of any new pain the resident was having. She stated the resident did not like getting out of bed, only for special events, and the resident council meetings. She stated she was made aware of the resident's injury when she returned to work on 04/08/24. She acknowledged completing an in-service on reporting changes in condition and notifying the physician. She stated the risk of not reporting the pain the resident had could result in serious injury like a broken bone. In an interview on 07/25/24 at 10:05 AM, the ADON stated she was familiar with the incident regarding Resident #25. She stated she heard the DOT was taking the resident back to her room and she had failed to put the footrests on the resident's wheelchair and the resident injured her leg. She stated she had not heard the resident complaining of pain until 04/06/24, and the weekend nurse contacted the physician, who referred her to the hospital for x-rays. She stated she had heard a couple of days later of what happened after speaking with the resident. She stated the CNA was supposed to notify the nurse of any pain a resident was having so that the nurse can follow up with the resident to assess what was wrong. She stated she nor the nursing staff received any reports of the resident having any new pains. She stated the resident rarely got out of her bed and she had not gotten out of bed that week (04/03/24 to 04/05/24). She stated the risk of not reporting the incident could result in the resident experiencing a severe injury and having pain untreated. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 07/25/24 at 10:25 AM, the Administrator stated that he knew of the incidents that occurred with Resident #25, and he stated it should have been reported sooner, which was why he had suspended and later terminated the DOT for being neglectful. He stated he had met with all staff and had in-serviced them on reporting injuries, fall protocols, and proper wheelchair transport and positioning on 04/08/24. He stated that he decided to terminate the DOT because of her not reporting the incident and her being neglectful in not using the resident footrest. He stated he had made several attempts to contact the DOT to interview her, but she had not returned his call. He stated the risk for not using the footrest and not reporting the incident once the incident had occurred was not good for the resident because she had a serious injury that went unnoticed for several days. In an interview on 07/25/24 at 03:10 PM, the Nurse Practitioner stated he was advised of the incident that occurred with the resident on 04/06/24. He stated when he was advised that the resident was complaining of pain in her leg, he immediately had her sent out for x-rays. He stated he was made aware that there was an incident involving a wheelchair and she had twisted her left leg. He stated the resident sustained a fracture below her knee, but it did not result in her needing a cast on her leg but instead a leg immobilizer. He stated the resident rarely left her bed and could have had pain when readjusting herself in bed. Attempts were made to contact the DOT for an interview on 07/24/24 at 12:00 PM, on 07/25/23 at 11:00 AM, and on 08/06/24. Each time the phone went straight to voicemail. The noncompliance was identified as past noncompliance (PNC) The IJ began on 04/02/24 and ended on 04/08/24. The facility had corrected the noncompliance before the state's investigation began: The facility re-educated the staff on Policy and procedure for Wheelchair transport and positioning, Patient Safety and Incident Reporting; and Fall Protocol. The facility conducted an AD Hoc Quality Assurance Meeting and terminated the previous Director of Therapy prior to the beginning of the HHSC investigation on 07/22/24. The Staff confirmed when interviewed they were adequately trained to report immediately to the Administrator, if they heard or suspected abuse, neglect or exploitation.

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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** 45055 Based on observations, interviews, and record review, the facility failed to ensure that residents, who needed respiratory care, were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for two (Residents #20 and Resident #45) of eight residents reviewed for Respiratory Care. 1. The facility failed to ensure Resident #20's breathing mask was properly stored. 2. The facility failed to ensure Resident #45's nasal cannula (flexible tube used to deliver oxygen to the nose through two prongs) was properly stored. These failures could place the residents at risk for respiratory infection and not having their respiratory needs met. Findings included: 1. Review of Resident #20's Face Sheet, dated 07/23/2024, reflected that the resident was an [AGE] year-old female admitted on [DATE]. Relevant diagnoses included chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs) and shortness of breath. Review of Resident #20's Comprehensive MDS Assessment, dated 07/05/2024, reflected that the resident had a moderate impairment in cognition with a BIMS score of 12. The Comprehensive MDS Assessment indicated Resident #20 was on oxygen therapy while a resident of the facility. Review of Resident #20's Comprehensive Care Plan, dated 07/09/2024, reflected that the resident had diagnosis of COPD, was at risk for shortness of breath, and one of the interventions was to administer medications/breathing treatment as ordered. Review of Resident 20's Physician's Order, dated 09/19/2023, reflected budesonide suspension for nebulization 0.5 mg/2 mL 1 vial via nebulizer twice a day for chronic obstructive pulmonary disease. Observation and interview with Resident #20 on 07/23/2024 at 9:37 AM revealed Resident #20 was on her bed, awake. Resident #20's nebulizer machine was noted sitting on top of the resident's side table. A breathing mask was connected to the nebulizer machine. The breathing mask was on top of the nebulizer machine. The breathing mask was not bagged. The part of the nebulizer mask that touched the face when in use was in contact with the top of the nebulizer machine. Resident #20 said she was on a breathing treatment for the longest time because of her breathing problem. Resident #20 said the nurse would put a solution on the container connected to the mask, would turn it on, and would put the mask on her face. Resident #20 continued that the nurse would go out of the room and would sometimes come back to take off the mask and put it on the table. Resident #20 said she was not sure if the nurse was putting it in a bag but she never saw a bag for her nebulizer mask. 2. Record review of Resident #45's Face Sheet, dated 07/23/2024, revealed that the resident was a [AGE] year-old female admitted on [DATE]. Relevant diagnoses included COPD and shortness of breath. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #45's Comprehensive MDS Assessment, dated 05/05/2024, reflected that the resident had a moderate impairment in cognition with a BIMS score of 10. The Comprehensive MDS Assessment indicated Resident #45 was on oxygen therapy while a resident of the facility. Review of Resident #45's Comprehensive Care Plan, dated 05/21/2024, reflected that the resident had diagnosis of COPD, was at risk for shortness of breath, and one of the interventions was administer O2 as ordered. Review of Resident #45's Physician Order, dated 08/18/2023, reflected O2 at 2-3 liters per minute via nasal cannula Every Shift - PRN. Observation on 07/23/24 at 10:30 AM revealed Resident #45 was on her bed sleeping. It was observed that the resident had an oxygen concentrator at bedside. A nasal cannula was attached to the oxygen concentrator. The nasal cannula was hanging on the oxygen concentrator. The nasal cannula was not bagged and there was no plastic bag on the concentrator. Observation and interview with LVN H on 07/23/2024 at 11:08 AM, LVN H stated the breathing mask, and the nasal cannula should not be exposed nor touching anything because it could cause cross contamination and infection. LVN H said the breathing mask and the nasal cannula should be bagged when not in use. LVN H went inside Resident #20's room and confirmed the breathing mask on top of the nebulizer machine. LVN H said he administered the resident's breathing treatment but was not able to put the mask in the plastic bag when the treatment was done. LVN H disconnected the breathing mask, said he would get a new one and would put it in a plastic bag. LVN H then went to Resident #45's room and confirmed the resident's nasal cannula was hanging on the oxygen concentrator. LVN H disconnected the nasal cannula attached to the oxygen concentrator, said he would replace it, and would get a plastic bag for it. In an interview with the DON on 07/24/2023 at 4:00 PM, the DON stated the breathing mask, and the nasal cannula should be bagged when not in use. The DON said the proper way of storing the breathing mask and the nasal cannula was putting them inside the plastic bag when the resident was done with the breathing treatment or when the resident was not using the nasal cannula. She said if those breathing apparatus were not bagged, exposed, or touching surfaces that were not clean, then oxygen administration could be compromised. The DON said the staff, including her, were responsible in monitoring that the apparatus used in oxygen therapy were bagged when not in use. She said the expectation was the breathing mask and the nasal cannula would be stored properly. The DON said she would continually remind the staff to be diligent in making sure the procedures for respiratory care were followed. She said she re-educated the staff providing direct care. In an interview with ADON E on 07/24/2024 at 5:03 PM, ADON E stated the breathing mask, and the nasal cannula should be bagged when the resident was not using it to prevent cross contamination and infection. She said it would only take a few seconds to bag the breathing mask and the nasal cannula. She said the staff who took off the mask should put it in a bag. She said if the resident was the one taking it off, there should be a bag ready for them to put the mask in. She also said that the resident should be educated why the mask should be bagged. She said the expectation was for the staff to bag the breathing mask and the nasal cannula. She said she would coordinate with the DON to do an in-service pertaining to bagging the nasal cannula and the breathing mask when the residents were not using them. She said she would round to check if there were bags for those residents using a breathing mask and nasal cannula and check if they were bagged when not in use. (continued on next page)

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	676247	A. Building B. Wing	07/25/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Administrator on 07/24/2024 at 5:11 PM, the Administrator stated everything used by the residents should be kept clean. He said the nasal cannula and the breathing mask should be stored properly to prevent respiratory infections. The Administrator said the expectation was for the staff to do their due diligence in order to provide the highest level of respiratory care. The Administrator said he would coordinate with the clinicians to address the issue. Review of facility policy Respiratory Treatment, Care, and Services Program Nursing Policies and Procedures revised May 5, 2023, revealed, Policy: The Facility ensures the safe, appropriate, and effective provision of respiratory treatment, care, and services in accordance with professional standards of practice . 6. Infection control practices including standard and transmission-based precautions are followed during . B. Handling of equipment, including cleaning, storage, and disposal of regular and biohazardous waste.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055 Based observations, interviews, and record review, the facility failed to maintain an Infection Prevention and Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for seven (Resident #100, Resident #20, Resident #18, Resident #10, Resident #30, Resident # 36, and Resident #53) of eighteen residents observed for Infection Control. 1. The facility failed to ensure that CNA C changed her gloves and performed hand hygiene while providing incontinent care to Resident #100. 2. The facility failed to ensure that RN G would not bring the whole container of test strips for checking blood sugar inside Resident #100's room. 3. The facility failed to ensure that MA D completed hand hygiene during medication administration. 4. The facility failed to ensure that RN F and CNA B completed hand hygiene during Resident #53's wound care and incontinent care. These failures could place the residents at risk of cross-contamination and development of infections. Findings included: 1. Review of Resident #100's Face Sheet, dated 07/23/2024, reflected the resident was a [AGE] year-old female admitted on [DATE]. Relevant diagnoses included kidney failure and pneumonia (inflammation and fluid in the lungs caused by a bacterial, viral, or fungal infection). Review of Resident #100's Comprehensive MDS Assessment, dated 07/25/2024, reflected Resident #100 had a severe impairment in cognition with a BIMS score of 07. The Comprehensive MDS Assessment indicated Resident #100 needed assistance for personal hygiene. Observation on 07/23/2024 at 4:11 PM, CNA C stated she would provide incontinent care for Resident #100. She said the resident was a new admission and she would change her before dinner. CNA C prepared the brief and wipes. CNA C washed her hands and then put on a pair of gloves. CNA C raised the bed and lowered the head of the bed. After lowering the head of the bed, CNA C unfastened the brief on both sides, and pushed the front part of the brief between the legs of the resident. CNA C pulled some wipes and started to clean the front part of the resident from front to back. She did it five times. CNA C rolled the resident towards the wall and cleaned the bottom of the resident. After cleaning the resident's bottom, CNA C rolled the soiled brief and the bed padding altogether towards the middle of the bed. After rolling the soiled brief and padding, CNA C rolled back the resident and instructed the resident to roll to the other side. After rolling the resident to the other side, CNA C pulled the soiled brief and padding and threw them in the trash can. CNA A took the new brief and put it at the bottom of the resident and fixed it. CNA A did not change her gloves nor sanitize her hands before touching the new brief. CNA A rolled the resident back, fixed the new brief, and taped the brief on both sides. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with CNA C on 07/23/2024 at 4:26 PM, CNA C stated she washed her hands before and after doing incontinent care. She said she did roll the soiled brief and padding altogether and then threw them into the trash can. She said she did not change her gloves nor did hand hygiene before touching the new brief. She said she should have changed her gloves after pulling the soiled brief and padding because her gloves were considered soiled after they came in contact with the soiled brief. She said the padding was also considered dirty because it came in contact with the soiled brief. She said not doing hand hygiene and not changing the gloves could cause transfer of contaminants from dirty to clean. She said cross contamination could eventually cause infection. 2. Review of Resident #100's Face Sheet, dated 07/23/2024, reflected resident was a [AGE] year-old female admitted on [DATE]. Resident #100 was diagnosed with type 2 diabetes mellitus (high blood sugar). Review of Resident #100's Comprehensive MDS Assessment, dated 07/25/2024, reflected Resident #100 had a severe impairment in cognition with a BIMS score of 07. The Comprehensive MDS Assessment indicated Resident #100 needed assistance for personal hygiene. Review of Resident #100's Physician's Order, dated 07/22/2024, reflected Novolog Mix 70-30FlexPen U-100 (insulin aspart) twice a day for type 2 diabetes mellitus. Observation on 07/23/2024 at 4:38 PM revealed RN G was about to check Resident #100's blood sugar. RN G pushed the nurse's cart to Resident #100's room. RN G sanitized her hands and sanitized the glucometer. RN G then prepared three alcohol wipes and a lancet. RN G then put a test strip on the glucometer. RN G went inside Resident #100's room and told the resident she would be checking her blood sugar. RN G brought with her the wipes, the lancet, the glucometer with test strip, and the whole container of the test strips inside resident #100's room. RN G put the container of the test strip on Resident #100' overbed table. RN G put on a pair of gloves, wiped the resident's right index finger, wait for it dry up, and then pricked the right index finger with the lancet. RN G scooped a drop of blood from the resident's index finger with the tip of the test strip that was inserted in the glucometer. After scooping the blood, the glucometer displayed error. RN G took another test strip from the container placed on top of the resident's overbed table and inserted it again to the glucometer. RN G repeated the process. After checking the blood sugar, RN went back to nurse's cart to prepare Resident #100's required insulin. After administering the insulin, RN G went back to the cart. When RN G was about to push the cart, she went back to the resident's room, took the container of test strip from the resident's overbed table, and put the container inside the first drawer of the cart. In an interview with RN G on 07/23/2024 at 4:54 PM, RN G stated she sanitized the glucometer before using it for Resident #100. She said when she went inside Resident's 100 room, she brought with her the alcohol wipes, a lancet, and the glucometer with a testing strip. She said she also brought with her the container of the test strips. She said she brought it inside in case she needed another test strip. She said she should have left the container of test strips on top of the cart because the strip was for all the residents that needed their blood sugar checked. She said if the if the container of test strip was for Resident #100 only, she could bring it inside. She said bringing an item inside the resident's room, putting it on the resident's table, and then using it to another resident could result to cross contamination. 3. Review of Resident #18's Face Sheet, dated 07/24/2024, reflected that resident was a [AGE] year-old female admitted on [DATE]. Resident #18 was diagnosed with anxiety disorder. (continued on next page)

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	676247	A. Building B. Wing	07/25/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #18's Comprehensive MDS Assessment, dated 04/07/2024, reflected that the resident had a severe impairment in cognition with a BIMS score of 03. The Comprehensive MDS Assessment indicated Resident #18 had anxiety disorder. Review of Resident #18's Comprehensive Care Plan, dated 07/09/2024, reflected that the resident received antianxiety medication related to anxiety. Review of Resident #18's Physician Order, dated 12/20/2023, reflected lorazepam tablet 0.5 mg. Give 1 tablet by mouth for anxiety, PRN. Observation on 07/24/2024 at 7:17 AM revealed MA D was preparing Resident #18's medication. He did not wash his hands nor sanitize his hands before preparing Resident #18's medication. After preparing the medications, MA D went inside the resident's room and gave the medication. After giving the medications, MA D went back to his medication cart and pushed the cart to Resident #10's room. He did not do hand hygiene. Review of Resident 10's Face Sheet, dated 07/24/2024, reflected resident was an [AGE] year-old female admitted on [DATE]. Resident #10 was diagnosed with major depressive disorder. Review of Resident #10's Quarterly MDS Assessment, dated 05/05/2024, reflected resident was cognitively intact with a BIMS score of 15. The Quarterly MDS Assessment indicated Resident #10 had depression. Review of Resident #10's Comprehensive Care Plan, dated 05/13/2024, reflected resident had a diagnosis of depression and was at risk for potential isolation, decreased/increased appetite, and changes in mood. Review of Resident #10's Physician's Order, dated 07/31/2023, reflected Escitalopram oxalate tablet 10 mg, one tablet by mouth once a day for depression. Observation on 07/24/2024 at 8:13 AM revealed MA D was preparing Resident #10's medications. He did not wash his hands nor sanitize his hands before preparing Resident #10's medication. After preparing the medications, MA D went inside the resident's room and gave the medications. After giving the medications, MA D went back to his medication cart and pushed the medication cart to Resident #36's room. He did not do hand hygiene. Review of Resident 36's Face Sheet, dated 07/24/2024, reflected resident was a [AGE] year-old male admitted on [DATE]. Resident #36 was diagnosed with dementia. Review of Resident #36's Quarterly MDS Assessment, dated 05/05/2024, reflected resident had a severe impairment in cognition with a BIMS score of 03. The Quarterly MDS Assessment indicated Resident #36 had dementia. Review of Resident #36's Comprehensive Care Plan, dated 05/13/2024, reflected resident had a diagnosis of dementia and was at risk for increased confusion, and decline in ADLs as the disease progresses. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #36's Physician's Order, dated 10/01/2023, reflected Aricept tablet 5 mg 1 tablet by mouth once a day for dementia. Observation on 07/24/2024 at 8:22 AM revealed MA D was preparing Resident #36's medication. He did not wash his hands nor sanitize his hands before preparing Resident #36's medication. After preparing the medications, MA D went inside the resident's room and gave the medications. After giving the medications, MA D went back to his medication cart. He did not do hand hygiene. Observation and interview with MA D on 07/24/2024 at 9:48 AM, MA D stated he must wash his hands or sanitize his hands before and after administering medications. MA D said hand hygiene was the most effective way to prevent transfer of contamination. MA D went inside Resident #36's room and pointed to the hand sanitizer dispenser located inside Resident #36's room. He said he should have sanitized his hands on his way out of the residents' room. MD D said not washing or sanitizing his hands could cause cross contamination and probable infection. 4. Review of Resident #53's Face Sheet, dated 07/23/2024, reflected resident was a [AGE] year-old male admitted on [DATE]. Resident #53 was diagnosed with a pressure ulcer of the left buttock. Review of Resident #53's Quarterly MDS Assessment, dated 06/25/2024, reflected Resident #53 was cognitively intact with a BIMS score of 15. The Quarterly MDS Assessment indicated that resident had a pressure ulcer at the time of admission. Review of Resident #53's Comprehensive Care Plan, dated 06/05/2024, reflected Resident #53 had an actual pressure ulcer on sacral (bone at the buttocks) related to dependent on mobility/paraplegia (paralysis of the legs and the lower body). Review of Resident #53's Physician Order, dated 06/27/2024, reflected BID Wound Treatment: Location left buttocks: clean with Dakins and apply alginate rope with silver cover with gauze island with border dressing and tape every day. Observation on 07/24/2024 at 10:51 AM revealed RN F was about to do Resident #53's wound care to left ischium. CNA B was with RN F to assist the resident to turn. RN F and CNA B both washed their hands and then both put on a gown and gloves. RN F positioned herself on the left side of the resident while CNA B was on the right side. RN F placed the resident's overbed table at the left side of the resident's bed. On the table were Dakins solution, calcium alginate with silver, gauze, border dressings, and a box of gloves. There was no hand sanitizer on the table. CNA B unfastened the resident's brief and assisted the resident to turn to his right side. RN F took off the old dressing, threw it in the trash can, and took off her gloves. RN F put on a new pair of gloves. She did not sanitize her hands before putting on the new pair of gloves. RN F started to clean the wound. During the process of cleaning the wound, Resident #53 had a bowel movement. RN F temporarily stopped wound care and started cleaning the resident's bottom. CNA B assisted with incontinent care. When incontinent care was done, RN F and CNA B both took off their gloves and put on new pair of gloves. They did not do hand hygiene before putting on new pair of gloves. RN F proceeded and finished with wound care. Both staff washed their hands after wound care. (continued on next page)

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	07/25/2024

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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with RN F on 07/24/2024 at 11:29 AM, RN F stated she did change her gloves but did not do hand hygiene in between changing of gloves while doing Resident #53's incontinent care and wound care. She said she should have sanitized her hands before putting on a new pair of gloves or when changing the gloves to prevent the spread of germs from the hands to the new pair of gloves. She said she would include hand sanitizer on her wound care treatment list to make sure the sanitizer would be on the wound care treatment table every time she would do wound care. In an interview with CNA B on 07/24/2024 at 12:01 PM, CNA B stated she assisted RN F during wound care. She said the resident had a bowel movement while RN F was doing wound care. She said they cleaned Resident #53's bottom before RN F continued with wound care. She said she changed her gloves but did not sanitize when she changed her gloves. She said it was important to do hand hygiene after removing the gloves because the germs from the used gloves could have touched the hands or wrist and could transfer to the new gloves if the hands were not sanitized. She said this could cause cross contamination and infection. In an interview with the DON on 07/24/2023 at 4:00 PM, the DON stated all the staff should know that hand hygiene was the most effective way to prevent cross contamination and infection. She said, first, the gloves should be changed after touching any soiled items. She said for this case, the gloves should have been changed after pulling the soiled brief. She continued that secondly, every time staff change their gloves, they should do hand hygiene before putting on a new pair of gloves. She said there could be instances that while they were providing care, the staff did not notice the gloves were torn, and the germs could enter the gloves and soil the hands. She said that was why it was important to do hand hygiene when changing the gloves. She said this should have been done during incontinent care and wound care. She said, third, the staff should do hand hygiene before and after any care including medication administration. She said, fourth, the test strips for blood sugar checks that were being used for all the residents with diabetes should stay on the cart and not be brought inside any resident's room. She said this also could cause cross contamination. She said any germs from the resident's overbed table could transfer to the container of the test strips. She said there might be no procedure specific for not bringing the container inside, but the best practice was to not take the container inside. She said the expectation was for the staff to do hand hygiene before and after any care, to change their gloves from dirty to clean, to do hand hygiene in between residents, and not to bring any item used by other residents inside a resident's room. She said she will do an in-service about infection control immediately after the interview. She said she needed to know the root cause of this issue to address the infection control issues. (continued on next page)

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	676247	A. Building B. Wing	07/25/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with ADON E on 07/24/2024 at 5:03 PM, ADON E stated hand hygiene was included in all the procedures of any care. She said the staff should be mindful that they were to take care of the residents and not give them additional issues or aggravate any medical issue the residents already had. She said gloves should be changed after touching the soiled brief and padding. She said the hands should be washed or sanitized before putting on a new pair of gloves. She said hand hygiene should be done after administering medications. She also said the test strips container should stay in the cart and the staff should have just brought a couple of strips in case there was an error in checking the blood sugar. She said the strips brought inside the resident's room should be discarded if not used. She said all the issues discussed were causes of cross contaminations and probable development of infections. She said the expectation was for the staff to do hand hygiene before and after every care including medication administration, after they change their gloves when transitioning from a dirty area to a clean area, sanitizing their hands when changing their gloves, and not bringing any item inside the resident's room if used for other residents. ADON E said she would coordinate with the DON on how to go forward. In an interview with the Administrator on 07/24/2024 at 5:11 PM, the Administrator stated not doing hand hygiene before and after any care, not changing the gloves after touching soiled items, not sanitizing the hands in between changing of gloves, and bringing items used by other residents inside a resident's room could contribute to cross contamination and probable infection. He said the expectation was for the staff to follow the policy and procedures pertaining to infection control. He said he would collaborate with the clinicians to in-service the staff about infection control. Review of facility policy, Hand Hygiene/Handwashing Infection Prevention and Control Policies and Procedures revised May 15, 2023, revealed Policy: proper hand hygiene/handwashing will be accomplished at all times . Note: Hand hygiene/handwashing is the most important component for preventing the spread of infection . Procedures: 1. Hand hygiene/handwashing is done . Before . A. Before patient/resident contact . After . A. After contact with soiled or contaminated articles such as articles that are contaminated with body fluids . B. After patient/resident contact . H. After removal of medical/surgical or utility gloves . I. Contact with a patient's/resident's intact skin (e.g. taking the pulse or blood pressure . Contact with environmental surfaces in the immediate vicinity of patient/resident. Review of facility policy, Infection Prevention and Control Program and Plan Infection Prevention and Control Policies and Procedures revised May 15, 2023, revealed Purpose: to establish . a system for preventing . controlling infections . Procedures . 6. Proper handling of linens, wastes, equipment, and supplies.