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	12/19/2024

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 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** 47743 Based on observation, interviews, and record review, the facility failed to ensure that a resident who needed respiratory care was provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one (Resident #1) of three residents reviewed for Respiratory Care. The facility failed to ensure Resident #1's nasal cannula was properly stored when not in use. This failure could place residents at risk for respiratory infection and not having their respiratory needs met. Findings included: Review of Resident #1's Face Sheet, dated 12/19/2024, reflected the resident was an [AGE] year-old female admitted on [DATE]. The resident was diagnosed with chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs). Review of Resident #1's Quarterly MDS Assessment, dated 12/16/2024, reflected the resident was cognitively intact with a BIMS score of 13. The Quarterly MDS Assessment indicated Resident #1 was on oxygen therapy while a resident of the facility. Review of Resident #1's Comprehensive Care Plan, dated 10/10/2024, reflected the resident required oxygen therapy related to COPD and one of the interventions was administer oxygen at 2 - 3 L via nasal cannula. Review of Resident #1's Physician Order, dated 03/19/2021, reflected O2 @ 2-3L/MIN CONTINUES VIA NC. Observation on 12/19/2024 at 9:49 AM, revealed Resident #1 was not inside her room. It was observed that there was an oxygen concentrator beside her bed. A nasal cannula was attached to the oxygen concentrator. The nasal cannula was hanging on top of the oxygen concentrator and was not bagged. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676247	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER Sandy Lake Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1410 E Sandy Lake Rd Coppell, TX 75019	

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview with CNA B on 12/19/2024 at 9:57 AM, CNA B said she assisted Resident #1 to transfer to her wheelchair. She said she took off the nasal cannula before she transferred her and put it on top of the oxygen concentrator. She said it should be placed inside a plastic bag to keep it clean. She looked for a plastic bag behind the oxygen concentrator but did not see one. While in the process of looking for a plastic bag, CNA B placed the nasal cannula on top of the bed. She said she would call the nurse to get plastic bag. Observation and interview with RN A on 12/19/2024 at 10:08 AM, she said the nasal should be bagged when not in use to keep it clean and prevent respiratory infection. RN A went inside Resident #1's room and saw the nasal cannula on top of the bed. She disconnected the nasal cannula and threw it in the trash can. She said she would get a new nasal cannula and a plastic bag. RN A went out of the room and returned with a new nasal cannula and a plastic bag. She said sometimes the resident would take it off but was not an excuse for her to check if the nasal cannula was bagged. In an interview with the DON on 12/19/2024 at 10:49 AM, the DON stated the nasal cannula should not be left hanging on the oxygen concentrator or placed on top of the bed to prevent respiratory infections and exacerbations of respiratory issues for those residents that already had respiratory challenges. The DON said the expectation was for the staff to make sure the nasal cannula were bagged. She said, actually, it was not the resident's responsibility to put the nasal cannula but management could educate the resident to put the nasal cannula in a bag if she would take it off. She said she do an in-service about bagging the nasal cannula and would personally monitor their adherence to the policy. In an interview with the Administrator on 12/19/2024 at 12:10 PM, the Administrator stated the nasal cannula connected to the oxygen concentrator should be in a bag when the resident was not using it to prevent cross contamination and infection. She said the expectation was the nasal cannula would be bagged when the resident was not using it. She said the DON already started an in-service to remind the staff to place a plastic bag near the oxygen concentrator and to bag the nasal cannula when not in use. Record 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 . 5. Respiratory Equipment Maintenance . B. Handling of equipment, including cleaning, storage.

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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 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** 50444 Based on observations, interviews, and record review, the facility failed to maintain an infection control program designed to help prevent the development and transmission of disease and infection for 1 (Resident #22) of 2 residents reviewed for infection control. The facility failed to ensure Resident #22's foley catheter bag (collects urine drained from the bladder) was not touching the floor on 12/19/24. This failure could place the residents at risk for the development and transmission of infections. Review of Resident #22's Face Sheet, dated 12/19/24, reflected Resident #22 was a [AGE] year-old male admitted to the facility on [DATE] with neuromuscular dysfunction of the bladder (nerves controlling bladder function are damaged). Review of Resident #22's Comprehensive Care Plan, dated 12/02/24, reflected Resident #22 had an indwelling foley catheter and was at risk for urinary tract infections. One intervention was to always apply appropriate infection precautions during care. Record review reflected a physician's order, dated 10/03/24, for Resident #22 to have an indwelling foley catheter for a neurogenic bladder (bladder dysfunction cause by nervous system conditions) and to empty the foley catheter bag every shift and document output. Review of Resident #22's Quarterly MDS (tool to measure health status) Assessment, dated 09/29/24, does not reflect a BIMS (tool to evaluate cognitive function) score because resident refused to answer/provided nonsensical answers. Section H reflected Resident #22 had an indwelling foley catheter. During observation and interview on 12/19/24 at 09:35 AM, Resident #22 was lying in bed looking at his cell phone. Resident #22's foley catheter bag was on the floor next to the bed. Resident #22 stated he had to get the catheter a couple of months ago and that it was usually hung on the side of the bed. In an interview 12/19/24 at 09:39 AM, LVN G stated the foley bag should not have been on the floor. LVN G entered Resident #22's room and hooked the foley bag on the side of Resident #22's bed. The bottom of the foley bag was touching the floor. When asked about this, LVN G adjusted the bed height to prevent the catheter bag from touching the floor. LVN G stated it was important to keep the foley bag off the floor to prevent Resident #22 from getting an infection. In an interview 12/19/24 at 01:45 PM, the ADON stated Resident #22's foley catheter bag should not have been touching the floor. The ADON stated it was important to ensure foley catheter bags did not come in contact with the floor because that was an infection control issue. The ADON stated she was going to in-service staff about it. Review of the facility's policy Indwelling Urinary Catheter Care and Removal reflected Do not place the drainage bag on the floor, to reduce the risk of contamination and subsequent catheter associated urinary tract infections. Undated.