

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 04/17/2025
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	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41211</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure residents received adequate supervision to prevent accidents for one (Resident #1) of four residents reviewed for supervision.</p> <p>The facility failed to provide adequate supervision to prevent Resident #1, who had severe cognitive impairment from eloping from the facility on 03/21/25. The resident was found at an intersection, across the street from the facility. The resident did not sustain any injuries and was found by a pedestrian.</p> <p>The noncompliance was identified as PNC IJ. The noncompliance began on 03/21/25 and ended on 03/21/25. The facility corrected the noncompliance before the investigation began.</p> <p>This failure could place residents at risk for injury and/or death.</p> <p>Findings included:</p> <p>Review of Resident #1's Face Sheet, dated 03/21/25, revealed the resident was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included Senile Degeneration of Brain (encompasses a range of neurological disorders characterized by a progressive decline in cognitive function, impacting memory, reasoning, and the ability to perform everyday activities), Cerebral Infarction (also called ischemic stroke, a cerebral infarction occurs as a result of disrupted blood flow to the brain), Alzheimer's Disease (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks), Dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities), Anxiety Disorder (symptoms of intense anxiety or panic that are directly caused by a physical health problem), Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and Cognitive Communication Deficit (a communication difficulty caused by a cognitive impairment).</p> <p>Review of Resident #1's MDS (Minimum Data Set) assessment, dated 01/06/25, revealed the resident was sometimes understood by others and sometimes understood others, had a BIMS (Brief Interview for Mental Status) was 04, which indicates severe cognitive impairment, had impairment of his lower extremities and used a wheelchair to ambulate independently, able to ambulate without support from staff.</p> <p>(continued on next page)</p>

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
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the Elopement Risk Observation assessment dated [DATE], identified Resident #1 as having exit-seeking behaviors, as it indicated t he had attempted to leave the healthcare facility.</p> <p>Review of Resident #1's Care Plan, last Care Conference dated 08/29/24, revealed the resident had cognitive loss/Dementia as evidenced by long term memory recall, inability to understand commands/communication, poor decision-making; Related to diagnoses of Dementia and Cerebrovascular Accident, also known as a stroke. Goal: Resident #1 will understand helpful reminders, will have needs met by staff as identified or anticipated, will have minimal negative emotional distress related to cognitive issues. As evidenced by documentation in the medical record. Approach: Continue to assess periodically for changes in cognition, encourage decision-making when able, reinforce use of memory cues.</p> <p>Review of Resident #1's Care Plan, revised 03/21/25, revealed the resident will not have negative events related to wandering, will remine safely in the facility as evidence by documentation in the medical record. Approach: find placement for secured unit Approach: assist with 1:1 supervision at all times Approach: Attempt to identify patterns to time of increased wandering (shift change, evening, after family visits, when hungry or near mealtimes .- not if no patterns identified.) Approach: Resident will be assessed by activities and potential intervention are identified as: activities of interest include: (add preferences) The interventions will be noted on the POC. Approach: Resident will be identified to staff through the facility alert system as an elopement risk. Approach: Resident's physical needs will be met; hunger, thirst, toileting</p> <p>Review of Resident #1's Care Plan, last reviewed/revised on 03/25/25, revealed the Category of Behavioral Symptoms: Problem - Resident #1 wanders through out the facility, is a risk for 1. Elopement . Related to diagnosis of Dementia. Goal(s): Resident will not have negative events related wo wandering, will remain safely in the facility as evidence by documentation in the medical record. Approach(es): Resident eloped on 03/21/25. Resident receiving one and one monitoring. Social Worker working with Responsible Party to locate secure unit. Attempt to identify patters to time of increased wandering (shift change, evening, after family visits, when hungry or near mealtimes .not if no patters identified.) Resident will be assessed by activities and potential intervention are identified as: activities of interest include: The interventions will be noted on the Plan of Corrections. Resident will be identified to staff through the facility alert system as an elopement risk. Resident's physical needs will be met; hunger, thirst, toileting.</p> <p>Review of Resident #1's Admission Elopement Risk Observation Assessment, dated 04/30/24, revealed the resident was cognitively impaired with poor decision-making skills, confused, independent with aide (wheelchair) in mobility, and had a known history of wandering, placing him at significant risk for getting to potentially dangerous places (stairs, outside of facility).</p> <p>Review of Resident #1's Progress Notes, dated 03/21/25 at 3:24 PM, revealed the resident propelled himself out of the front entrance door and was noted outside the building. The resident was noted at the intersection from which the resident was assisted back to facility by responding staff. No acute s/s of distress noted.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Call placed to the Responsible Party to notify. The Responsible Party stated, Resident #1 use to be in the military and is super-fast and quiet. I know he's a pain in the butt. The Responsible Party apologized and thanked this writer for notifying her. The resident is currently with the assigned charge nurse head to toe assessment, skin assessment, hydration and Activities of Daily Living care implemented. Resident is currently in line of sight, one on one supervision of 1 staff. No signs/symptoms of distress noted. Call placed to physician; no new orders received. Date & Time Template Progress Notes 4/17/25, 3:18 PM</p> <p>Observation of the intersection on 04/16/25 at 9:00 AM, revealed the intersection began at the corner of the parking lot's west entrance. The intersection consists of three, eastbound lanes with the outermost lane for moving straight ahead or turning right onto another street. The innermost lane being a left turning lane, which leads into the facility's parking lot's west entrance. The intersection also consists of three westbound lanes with the innermost lane being a left turning lane and the outermost lane for moving straight ahead or turning right, into the facility's parking lot's west entrance. There was a median separating the two directions of traffic and there were traffic lights for both directions of traffic. The resident would have had to exit from the parking lot's west entrance, heading southbound, cross the street, stop at the median to avoid eastbound traffic, and then cross the eastbound lanes to reach the corner where the pedestrian stopped him and kept him, until the Administrator arrived. There were businesses on the block which the pedestrian stopped the resident and across the street, west of the businesses, was a gated senior living community. The resident had to cross six lanes to get to the other side of the street. The speed limit for the lanes going east and west bound was 40 miles per hour.</p> <p>An interview with the Receptionist on 04/16/25 at 10:11 AM, revealed the day of Resident #1's elopement, the front area was busy with a group of residents playing a card game and staff were passing through and talking. She stated she saw Resident #1 in the lobby area; however, he was not near the entrance door at the time. She stated when the vendor came in with another resident, they stopped at the counter, and she was talking to the vendor and the resident. She stated she did not notice that Resident #1 had reached the door and exited. She stated she contacted the vendor and told them that they had to make sure the door was closed behind them, whenever they entered and exited the facility, and they stated they understood. She stated she was instructed to contact the vendor, by the Administrator. She stated that day, the orange notice was placed on the door, telling visitors and vendors to make sure the door was closed when they enter and/or exit the facility.</p> <p>An interview with the Director of Nursing (DON) on 04/16/25 at 5:19 PM, revealed Resident #1 was an exit-seeker, he was already in the Elopement Risk Binder prior to the incident. She stated she did not know the last time he attempted or if he had ever been successful at eloping, prior to this date. She stated he had not attempted to elope since she had been at the facility, prior to the day of the incident. She stated the Elopement Risk Binder with residents' pictures are at the reception desk, and both nurses' stations. She stated the books are reviewed when new staff start and if there was an elopement attempt on the 24-hour Report, the binders are updated, and it was discussed during their shift changes and morning meetings. She stated they had not had an elopement, since she was at the facility. She stated they had Elopement Drills monthly and as needed. She stated they monitored Elopement Risk residents for change in condition, whether they declined, or their behavior increased, she stated any change in the resident, was discussed and they would update the binder and their care plans. She stated when this incident happened, they educated the staff, and the vendor was contacted to ensure they understood to make sure the door closed behind them.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>An observation on 04/16/18 at 6:28 PM, revealed the facility front door, which lead to the lobby, had a bright orange sign placed at eye-level, which instructed visitors and vendors to make sure all doors were closed behind them when they entered and exited the facility, to ensure residents were not able to leave the building unassisted.</p> <p>Interview with the Administrator on 04/17/25 at 9:25 AM, revealed Resident #1 had eloped from the facility through the front entrance. She stated the facility received a call from a pedestrian who found the resident on the corner of the intersection, across the street from the facility. The Administrator stated she was notified and immediately told other administrative staff. She stated she exited the building and saw Resident #1 across the street. She stated she went to the resident and asked him where he was going and he replied, I was trying to get away. She stated she assessed him and did not observe any signs of injury or distress. She told him he had to go back home and that she would take him. She stated the resident agreed. She stated by then, other staff had arrived, and they all escorted the resident back to the facility. She stated resident was assessed by a nurse and no injuries or signs of distress were noted. She stated the resident was placed on 1:1 monitoring, and the monitoring continued until he was discharged . She stated the resident's physician and Responsible Party was notified. She stated they reviewed video footage to determine how the resident exited the facility, and they saw that he stopped the door from closing, after a vendor entered the facility with another resident. She stated the vendor stopped at the reception desk and as was talking to the receptionist, the resident exited without being seen. She stated a Care Conference was set up and during the Care Conference, they discussed the resident requiring a secured unit being a more suitable placement for the resident and the Responsible Party agreed. She stated the Social Worker, assisted the Responsible Party with finding a facility with a secured unit. She stated the resident was discharged to the new facility on 03/26/25. She stated on the day of the elopement, all staff were in-serviced on Elopements, and she instructed the DON to post signs telling visitors and vendors to ensure the door closes completely, behind them.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the facility's Elopement Policy, dated 11/01/17, revealed Policy: To safely and timely redirect patients/residents to a safe environment. A prompt investigation and search will be conducted if a patient/resident is considered missing. The facility will determine a signal code, e.g. Code [NAME] to designate a missing patient/resident. Procedures: 1. Once it has been established that a patient/resident is missing, all employees are notified immediately by paging overhead Purple. 2. The DON/designee completes a missing resident profile. 3. The DON or designee organizes and institutes an immediate and thorough search of the center and surrounding grounds. The search should include but is not limited to a search of the area outside the nearest exit to the patient/resident's room or the exit where he/she was last seen, and the entire unit where the patient/resident resides or was last seen, the remainder of the facility (all rooms, closets - including storage facilities - and bathroom) and grounds, extending beyond the fence line. 4. The entire search process of the facility and grounds, from the time the patient/resident is missing, will be completed within (30) thirty minutes. 5. If the search fails to locate the missing patient/resident within (30) thirty minutes from the time the patient/resident is found missing, the Administrator or designee contacts the appropriate community agencies (Police, Local Health Department) and Administration, the patient/resident's legal representative and attending physician. Staff will provide the Police with all physical identifying information including but not limited to physical appearance, height, weight, age, sex, and clothing if known. 6. The search is continued. Two staff members search the surrounding streets by car for a (2) two-mile radius around the facility. 7. When the patient/resident is located, the Charge Nurse completes a head-to-toe assessment. The Social Services designee assesses the patient/resident for emotional distress. The Charge Nurse reports any findings to the DON or designee. The DON or designee notifies the Administrator/designee and notifies the appropriate community agencies, attending physician, and patient/resident's legal representative. 11. Facilities Quality Assurance Committee investigates the incident and implements interventions to prevent reoccurrences.</p> <p>The Administrator and DON were notified on 04/17/25 at 4:10 PM, that a Past Non-Compliance IJ situation had been identified due to the above failures. It was determined these failures placed Resident #1 in an IJ situation on 03/21/25. The facility implemented the following interventions:</p> <p>Interventions initiated prior to surveyor entry on 03/25/25:</p> <ul style="list-style-type: none"> * Daily inspection log of all exits beginning 03/21/25 * Elopement drills with all staff on 03/21/25 * Updated Care plan for Resident #1 on 03/21/25 * 100 % audit all residents for elopement risk. 03/21/25 * The facility conducted appropriate in-service trainings, on 03/21/25, in regard to: <p>Elopement Risk</p> <p>What to do if resident is missing</p> <p>Abuse, Neglect, and Exploitation</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>* Resident #1 was discharged from the facility to another facility, accompanied by a C.N.A. via transport in wheelchair. The resident departed in stable condition with all remaining belongings and medication. Copy of face sheet and Continuity of Care Documents were sent with the resident on 03/26/25.</p> <p>There had been no previous and no new incidents for any additional residents as of 03/21/25.</p> <p>Interviews:</p> <p>04/16/25 at 5:41 PM with C.N.A. A, revealed Elopement In-services on checking doors to make sure they are closed. Check on the residents. They had to always try to keep residents who moved around all the time, in an area where everyone could see them and know where they were. If an alarm went off, they would check the doors to see if they could see who went out or was trying to go out. They were then supposed to go outside and look around the parking lot and the sidewalk out front, to see if they could see a resident. If no residents were found, they were supposed to come back in and locate all of their assigned residents. They would check the Elopement Binder to make sure those residents were in the building. They would report to the nurse that all of their people were in the building. She stated if a resident eloped, they would call Code Purple over the speakers. She stated they would round on their residents every 15 to 30 minutes because they had to constantly be working and making sure the residents were ok and to see if they needed something. She stated if she saw a resident going toward an Exit door, she would run and get them and redirect them. If its someone who was combative, she would call for help and then try to redirect them. She stated they were told to not give the door code to visitors and vendors. She stated they were also told to tell visitors and vendors to make sure the door closed behind them. She stated the back door was only used for staff and vendors who were bringing in supplies. She stated everyone else had to use the front door to enter and exit the building. She stated they never used the side doors that had a sign saying This is not an Exit. She stated they were for emergencies only. She stated when they were doing 1:1 monitoring, they would have to stay with that resident at all times. She stated if they need to go to the restroom, they have to get someone to sit with the resident until they get back. She stated even if the resident is asleep, they have to stay in the room with them, in case they get up. She stated 1:1 monitoring would last as long as they were told to do it. She stated she was not assigned to be on 1:1 monitoring for Resident #1. She stated she worked with Resident #1 and she never saw him trying to get out of the building. She stated if she witnessed any type of abuse, she would report it to the nurse and to the Administrator. She stated if it was resident-to-resident abuse, she would separate them and call for help, then report it.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>04/16/25 at 5:38 PM with ADON R, revealed the last time they had an Elopement in-service was when they had an elopement in March. She stated they talked about what to do when an elopement occurs. She stated they were to check the doors to see if they can see who was at the door or went out of the door. She stated if they did not see anyone, they were supposed to go outside and search the parking lot and up and down the street. She stated if they did not see anyone, they were to come back in the building and search for the residents who were in the Elopement Binder, then make sure the rest of the residents were in the building. She stated once everyone had been accounted for, the aides were to report to the CNAs who would report to the ADONs The ADONs reported to the DON and Administrator. She stated the code word for an elopement was Purple. She stated in the in-service, they were told to tell visitors and vendors to make sure they physically close the door behind them, going and coming. She stated if they saw a resident attempting to exit, they would gently redirect them away from the door and would take them to where they could engage in an activity or where they could be seen by other staff. Such as at the nurses' stations.</p> <p>04/16/25 at 6:12 PM with ADON S, revealed she stated they had elopement skills drills every three months. She stated if an elopement happened, they would call a code purple and everyone had to search for the missing resident. She stated some staff would ensure that all of their residents were accounted for, while also looking for the missing resident. She stated other staff would search closets, empty rooms, storage rooms, and outside. She stated once the missing resident was found, they would assess the resident and a report would be written. She stated they had to notify the physician, family, Administrator, and DON. She stated staff were to remind vendors and visitors to make sure the doors closed behind them, when they entered and exited the facility.</p> <p>04/17/25 at 7:15 AM called RN E, no answer, and not able to leave a voice message.</p> <p>04/17/25 at 7:25 AM called C.N.A. P, no answer, and not able to leave a voice message.</p> <p>04/17/25 at 7:30 AM called LPN H, no answer, and not able to leave a voice message.</p> <p>04/17/25 at 10:31 AM with LVN J, revealed in-services were done quarterly and whenever there was an elopement incident. She stated if there was an elopement, the person who noticed a resident was missing, they were to call Code Purple. She stated some of them looked for the missing resident, while the others were going room-to-room counting everyone else to make sure everyone else was accounted for. She stated they looked throughout the building and outside. She stated there were signs on the doors for the visitors or vendors know to make sure the doors close behind them before walking off. She stated this was important so residents could not get out. She stated they walked around and made sure they knew where the residents were, who were an elopement risk. She stated even residents who were not at their baseline of behaviors, she watched them more diligently to make sure they did not slip out of the building or attempt to.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>04/17/25 at 9:22 PM with LPN L, revealed the last in-service on Elopement was a few weeks ago. She stated they were told to tell vendors and visitors to make sure the doors closed behind them, so the residents could not get out. She stated they had Elopement binders at the front desk and at the nurses' stations. She stated if someone was missing, they would call code purple and the aides check to see if all of their people were in the building, while the nurses looked, and other staff looked outside in the parking lot and the back of the building and up and down the street. She stated once the missing resident was found, a report would be written, and the DON and Administrator would be notified. She stated they had an elopement a few weeks ago and that was why they had the in-service.</p>		