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	05/13/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055 Based on observations, interviews, and record review, the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for three (Resident #1, Resident #2, and Resident #3) of eight residents reviewed for Reasonable Accommodation of Needs. The facility failed to ensure the call light system in Resident #1, Resident #2, and Resident #3's rooms were in a position that was accessible to the residents on 05/13/2025. This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency. Findings included: 1. Record review of Resident #1's Face Sheet, dated 05/13/25, reflected he was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included nausea with vomiting, and sepsis (complications from an infection). Record review of Resident #1's Quarterly Minimum Data Set (MDS) assessment, dated 03/07/25, reflected he had a BIMS score of 15 (intact cognitive response). For ADL care, it reflected the resident required extensive assistance. Record review of Resident #1's Comprehensive Care Plan, dated 03/03/2025, reflected the resident was a fall risk and one of the interventions was to be ensure the resident's call light was within reach. In an observation on 05/13/25 at 8:05 AM, Resident #1 was observed lying in bed and his call light was observed on the floor, near a wall, and out of reach for the resident. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676247	A. Building B. Wing	05/13/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation and interview on 05/13/25 at 8:07 AM, ADON F observed Resident #1's call light on the floor and out of reach for the resident's use. She stated the resident was capable of pressing the call light button whenever he needed assistance. She stated the call light should have been clipped near the resident so that he can alert staff if care was needed. She stated the risk of not having the call light near the resident could result in him having an emergency and not being able to contact anyone. She said staff should make sure the call lights were within reach of the residents before they leave the room so that the needs of the residents could be addressed and also to prevent falls. 2. Record review of Resident #2's Face Sheet, dated 05/13/25, reflected he was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included vomiting, and unsteadiness on feet. Record review of Resident #2's Quarterly Minimum Data Set (MDS) assessment, dated 02/28/25, reflected he had a BIMS score of 14 (intact cognitive response). For ADL care, it reflected the resident required extensive assistance. Record review of Resident #2's Comprehensive Care Plan, dated 02/13/25, reflected the resident had a history of falls and one of the interventions was to be ensure the resident used his call light for assistance. In an observation and interview on 05/13/25 at 8:10 AM, Resident #2 was observed lying in bed and his call light pad was observed on the floor, under the bed, and out of reach for the resident. Resident #2 stated he was soak and wet earlier in the morning and could not contact staff for assistance because he could not reach his call light. The resident stated he had cerebral Palsy, which causes him to shake a lot and could fall out of the bed. In an observation and interview on 05/13/25 at 8:11 AM, RN S was shown a picture of where Resident #2's call light pad was positioned under the bed, and she stated the call light should have been clipped near him. She stated she had checked on the resident earlier in the morning and the call light pad was positioned on the bed. She stated the call light should have been clipped near the resident so that he can alert staff if care was needed. She stated the risk of not having the call light near the resident could result in him having an emergency and not being able to notify staff. 3. Record review of Resident #3's Face Sheet, dated 05/13/25, reflected he was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included sepsis (complications from an infection), and unsteadiness on feet. Record review of Resident #3's Quarterly Minimum Data Set (MDS) assessment, dated 014/30/25, reflected he had a BIMS score of 13 (intact cognitive response). For ADL care, it reflected the resident required supervision or touching assistance. Record review of Resident #3's Comprehensive Care Plan, dated 04/25/25, reflected the resident was a risk for falls and needed a one person assist for ADL and mobility. In an observation on 05/13/25 at 8:20 AM, Resident #3 could be heard from the hall calling for assistance. After entering the resident's room, the call light was observed hanging on the wall, wrapped around a plugged-in air freshener, and out of reach for the resident. (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	05/13/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation and interview on 05/13/25 at 8:22 AM, CNA L, RN E, and the DON was shown where Resident #3's call light was positioned hanging on the wall, and the DON stated the call light should have been placed in reach of the resident. The DON stated the resident was a fall risk and his call light She have been placed near him just in case he had a fall or needed assistance. The DON stated she was unsure how the call light was placed there. In an interview on 05/13/25 at 10:20 AM, the DON stated she had in-serviced her staff today on ensuring call lights were placed in reach of the residents, making more frequents rounds to ensure call lights were in reach, and care planned residents who had a habit of moving their call lights. She stated the risk of the call lights not being in reach of the residents could prevent them from notifying staff if there was an emergency. Record review of the facility's policy Call Lights (05/05/23), revealed When leaving the patient or resident room, ensure the call light is placed within the patient's/resident's reach.