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	06/06/2025

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure nurses were able to demonstrate competency in assessment related to fall risk for 1 of 23 residents reviewed for fall risk assessments (Resident # 1). The facility failed to ensure LVN B was competent to accurately assess fall risks on 04/03/2025 and 06/03/2025. This failure could place the residents at risk for insufficient assessments and insufficient interventions for fall risk. Findings included: Review of Resident #1's Face Sheet dated 06/05/2025 revealed he was a [AGE] year-old male admitted to the facility on [DATE] for hospice care. Diagnoses included narcotic poisoning (overdose,) dementia (group of symptoms affecting memory, thinking, and social abilities,) vascular dementia (dementia caused by brain damage from impaired blood flow,) contractures of left lower leg (stiffening of muscles to prevent body movement,) pain disorder (chronic pain experienced in one or more areas of the body) and glaucoma (damage to the optic nerve affecting vision.) Diagnosis related to incident included displaced intertrochanteric (points where the muscles of the thigh and hip attach) fracture of the left femur (left hip fracture) and pain in left hip. Review of Resident #1's Comprehensive Care Plan, rev. 06/04/2025, revealed: 1.Resident #1 was at risk for falling related to medication use, cognition, vision, weakness, and history of falls. He required assistance for all mobility. Interventions included: -Verbal reminders to not ambulate/transfer without assistance -Close monitoring by staff while up on chair -Keep bed in lowest position with brakes locked -Call light in reach at all times (continued on next page)

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

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Personal items within reach -Provide resident an environment free of clutter -Provide toileting assistance 2. Resident #1 had a fracture to his left femur and was at risk for uncontrolled pain and infection. Interventions included: -Administration and monitoring of anticoagulants -Assessment of affected area every shift for changes -Maintain body in functional alignment -Report signs of venous thrombosis (blood clot) 3.Resident had an actual fall on 01/10/2025, 02/12/2025, 03/08/2025, and 04/02/2025. Interventions included: -Wheelchair brakes locked -Keep personal items and frequently used items within reach -Occupy resident with meaningful distractions -Observe frequently and place in a supervised area when out of bed Review of Resident #1's re-admission MDS dated [DATE] revealed his BIMS score was not completed because resident was rarely/never understood. Additionally, Resident #1 was scored as having short- and long-term memory problems, and his cognitive skills for daily decision making were moderately impaired. Resident #1 was assessed as having both lower and upper impairments of his extremities; but did not use any mobility aides. Resident #1 required substantial/maximal assistance with oral hygiene, toileting, upper body dressing, personal hygiene. Resident #1 was dependent upon staff for shower/baths, lower body dressing, and putting on/taking off footwear. Review of facility's Morse Fall Scale Assessment completed by LVN B, after the fourth documented fall, on 04/03/2025 reflected she documented Resident #1 had a history of falling, was on bed rest, had a weak gait, and was oriented to his own abilities. This data scored Resident #1 as a low fall risk. Review of facility's Morse Fall Scale Assessment completed 06/03/2025 at 12:25 AM by LVN B revealed Resident #1 had a history of falling, was on bed rest, and was oriented to his own abilities. This data scored Resident #1 as a low risk for falls. Review of facility's incident report dated 06/05/2025 revealed: (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	01/10/2025 at 11:55 PM Resident #1 was in the dining room found on floor, with no apparent injury 02/12/2025 at 4:45 AM Resident #1 was in the TV room found on floor, with no apparent injury 03/08/2025 at 4:10 PM Resident #1 was at the nurses' station, unwitnessed fall, with no apparent injury 04/02/2025 at 3:30 AM Resident #1 was found in his room on the floor, with no apparent injury Review of facility's post-fall assessments between 01/10/2025 and 04/02/2025 for Resident #1's falls revealed no evidence of documented injuries or signs and/or symptoms of pain from each assessment. Review of facility Progress Notes on 05/28/2025 at 2:33 PM, reflected RN S wrote that [Resident #1] was on his wheelchair with his left leg turned inward and looked uncomfortable. RN S stated she tried to fix left leg but seems like resident has pain while moving leg . Resident #1's provider was notified, radiology was ordered and obtained, and results were pending. In interview with RN S on 06/06/2025 on 11:52 AM, she stated she was Resident #1's nurse on 05/28/2025 and assisted Resident #1 to the wheelchair that day without any issue. She stated later during her shift she observed Resident #1's leg turned inward while he was in his wheelchair and that he appeared to be in pain. She stated she reported this to the provider and received an order for radiology. Review of Resident #1's Final X-Ray Report, dated 05/28/2025 revealed Examination Left Hip, Pelvis . Findings . Acute, transverse intertrochanteric fracture femur . In observation of Resident #1 on 06/05/2025 at 9:36 AM, resident appeared in his bed resting, clapping his hands. Resident #1's call light was observed nearby and within reach, personal items observed nearby on his bedside table, his immediate environment was observed to be free of clutter; but Resident #1's bed was not observed in its lowest position. Additionally, no fall mat was present at this time. CNA A entered the room and lowered Resident #1's bed to its lowest position. Interview with Resident #1 was not successful due to his cognitive abilities. In interview with CNA A on 06/05/2025 at 9:40 AM, he stated he lowered Resident #1's bed to its lowest position for safety. CNA A stated Resident #1 was a fall risk; but stated Resident #1 had no history of previous falls that he was aware of. In interview on 06/05/2025 at 11:35 AM with the facility nurse who assessed Resident #1 as a low fall risk, LVN B stated her overall impression of Resident #1 was that he was alert but confused. She stated Resident #1 would get up from bed without using his call light and was known to get out of bed without assistance. When asked if Resident #1 was aware of his abilities, she stated he was not aware at all. When asked if she completed Resident #1's Morse Fall Scale Assessments on 04/03/2025 and 06/03/2025 she said that she did. When asked how she assessed the resident, she stated I need more training on the assessment tool. After reviewing the assessments, she stated the assessments were not accurate, and that he was a high fall risk. She stated it was important to complete accurate assessments for the safety of the resident so proper interventions can be put in place. She stated inaccurate assessments can lead to incidents. She stated it was her responsibility as the nurse to complete accurate assessments so sufficient safety interventions can be put into place. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In interview with the DON on 06/06/2025 at 9:13 AM she stated Resident #1 was a high fall risk. When provided with facility's Morse Fall Scale Assessments from 04/03/2025 and 06/03/2025 she stated, that's not right. She stated she expected her nurses to complete accurate assessments because accurate assessments lead to appropriate interventions and good outcomes. She stated CNA A should ensure Resident #1's bed was at its lowest position for his safety and per his comprehensive care plan, and CNA A should have been aware of his fall history. She stated this information was accessible to all CNAs via the facility's POC system but this was populated from resident assessments so it might not have been indicated. DON further stated that Resident #1 had no injuries and accidents between April and the recent diagnoses of fracture, and that he probably obtained the fracture during a previous fall at the facility. She stated that the interventions the facility have implemented have been effective, but she would re-assess if a fall mat would be appropriate. In a follow up interview with the DON on 06/06/2025 at 2:41 PM she stated I think we've done everything to prevent [Resident #1's] falls. She stated that the fracture appeared to be in the healing stages and was not an acute injury. She stated she still thought it was a residual injury from the fall in April . She stated she has now implemented a fall mat for Resident #1 and will work on getting a low low bed. She stated these interventions were not in place previously but will be in place moving forward to prevent further incidents and/or injury. In interview with the facility Administrator on 06/06/2025 at 10:22 AM, she stated she felt the interventions they had in place for Resident #1 to prevent injury were effective. She stated she was not aware of what more could be implemented to prevent further falls, incidents, and injury. She stated it was the DON's responsibility to review each resident's falls and add needed interventions as necessary. She stated she expected her nurses to complete accurate assessment data and this was the responsibility of the clinical team led by the DON. Review of facility policy, Fall Management, rev. 05/05/2023, revealed The facility will identify each resident who is at risk for falls and will plan care and implement interventions to manage falls . The Fall Risk Evaluation assists in identifying the appropriate preventative interventions that will be recorded on the resident's care plan . The care plan reflects individualized interventions that are reassessed and revised as needed . Review of facility policy, Care Plan Process, Person Centered Care, rev 05/05/2023, revealed The facility will develop and implement a baseline and comprehensive care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meets professional standards of quality care . Thru ongoing assessment, the facility will initiate person-centered care plans when the resident's clinical status or change of condition dictates the need such as . falls.