

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 08/19/2025
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)		
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure the resident participated in the development and implementation of his or her person-centered plan of care, including the planning process, the right to identify individuals or roles to be included in the planning process, the right to request meetings, and the right to request revisions to the person-centered plan of care for 1 of 8 residents (Resident #5) reviewed for Care Plan development and assessments. The facility failed to ensure Resident #5 participated in the development of her Quarterly Care Plan assessment. This failure could place residents at risk of their needs not being met. Findings include: Record review of Resident #5's Face Sheet, dated 08/18/25, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #5 had diagnoses of End Stage Renal Disease (Kidney failure), and heart disease. Record review of Resident #5's Quarterly MDS Assessment, dated 07/15/25, reflected Resident #5 had an intact cognitive response with a BIMS score of 15. The Quarterly MDS Assessment reflected the resident required total assistance for ADL care and a treatment of hemodialysis (blood purifying). Record review #5's Comprehensive Care Plan, dated 08/12/25, reflected the resident's last care plan conference occurring on 03/18/25. In an interview on 08/17/25 at 11:50 AM, Resident #5 stated she had not had a care plan conference meeting in quite some time. She stated she was scheduled for a conference in June 2025, but it was canceled and never rescheduled. She stated she wanted to be a part of her care planning. In an interview on 08/18/25 at 11:41 AM, MDS Nurse C stated the social worker was responsible for setting up care plan conferences, but they did not currently have one, so the MDS nurses were responsible for scheduling the conference. She was advised Resident #5 stated she had not had a recent care plan conference and records indicated her last care plan conference occurred on 03/18/25 and her next conference was scheduled for 06/18/25, but it was canceled and never rescheduled. She stated she was unsure why the resident's care plan conference was canceled, and never rescheduled. She stated the resident's care plan conference was needed to ensure the resident, or their responsible party were aware of the plan of care and to get their buy-in of the care plan. In an interview on 08/19/25 at 12:53 PM, the DON was advised Resident #5's last care plan conference occurring on 03/15/25, and the resident stating that she had not had once since then. She stated she was in the hospital at the time, and the care plan conference was never rescheduled. She stated the social worker should have rescheduled the care plan conference, but it was overlooked. She stated the previous social worker was no longer at the facility. She stated going forward the resident will get her care plan conferences. She stated the importance of the resident getting the care plan conferences allowed her to express her needs, concerns, and obtain her input. Record review of facility's policy, CARE PLAN PROCESS, PERSON-CENTERED CARE (05/05/23) reflected The facility will coordinate the development of the person-centered care plan within the required timeframes. The IDT will invite participation from the resident and the resident's legal representative (if applicable). The IDT will document an explanation in the resident's medical record of the invitation, participation, or lack of participation of the resident and their resident representative if determined not practicable for the development of the resident's (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
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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	person-centered care plan. Residents will remain actively engaged in the person-centered care planningprocess and has the right to participate in the development of and be informed inadvance any changes to the person-centered care plan; see the person-centeredcare plan and choose to sign the care plan after significant changes.		

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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** Based on observation, interview and record review the facility failed to ensure residents had the right to a safe, clean, comfortable, and homelike environment including but not limited to receiving treatment, receiving housekeeping services, and supports for daily living safely for 15 of 20 resident rooms on the 300 and 400 halls (Resident room [ROOM NUMBER], #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, and #15) reviewed for a clean and homelike environment. The facility failed to ensure Resident rooms #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, and #15, were thoroughly cleaned and sanitized. This failure could place residents at risk of living in an unclean and unsanitary environment which could lead to a decreased quality of life. Findings include: An observation on 08/17/25 at 11:11 AM of resident room [ROOM NUMBER] reflected the air condition vents had dirt stains and dust between the vents. An observation on 08/17/25 at 11:16 AM of resident room [ROOM NUMBER] reflected the air condition vents had dirt stains and dust between the vents and the air filters had thick dust. A night light, located on the bottom of a wall near the door entrance, and thick black stains and dust on the cover. The toilet in the bathroom had brownish stains on the inside bowl. The bottom of the bed frame had dirt and light brownish stains. An observation on 08/17/25 at 11:21 AM of resident room [ROOM NUMBER] reflected the bathroom had [NAME] stains on the wall near an assist rail. The soap dispenser on the wall had dark stains on the bottom of the dispenser. A night light, located on the bottom of a wall near the door entrance, and dark stains and dust on the cover. On the bottom of the door frame were brownish spots. An observation on 08/17/25 at 11:25 AM of resident room [ROOM NUMBER] reflected a night light, located on the bottom of a wall near the door entrance, and dark stains and dust on the cover. The toilet in the bathroom had brownish stains on the inside bowl. On the bottom of the door frame were brownish spots. An observation on 08/17/25 at 11:31 AM of resident room [ROOM NUMBER] reflected the air condition vents had [NAME] stains on and between the vents. A bedside table in the room had brownish stains along the bottom of the frame. The base of the toilet had brownish stains around the bolt. The bathroom floor had dark gray and brownish stains near and around the toilet. An observation on 08/17/25 at 11:34 AM of resident room [ROOM NUMBER] reflected the base of the toilet had brownish stains around the bolt. The bathroom floor had dark gray and brownish stains near and around the toilet. An observation on 08/17/25 at 11:38 AM of resident room [ROOM NUMBER] reflected the air condition vents had [NAME] stains on and between the vents. A night light, located on the bottom of a wall near the door entrance, and dark stains and dust on the cover. An observation on 08/17/25 at 11:41 AM of resident room [ROOM NUMBER] reflected the air condition vents had [NAME] stains on and between the vents. The base of the toilet had brownish stains around the bolt. The bathroom floor had dark gray stains near and around the toilet and the corners of the floor. An observation on 08/17/25 at 11:44 AM of resident room [ROOM NUMBER] reflected the air condition vents had [NAME] stains on and between the vents. The bathroom floor had dark gray stains near and around the toilet and the corners of the floor. An observation on 08/17/25 at 12:02 PM of resident room [ROOM NUMBER] reflected the mini fridge had reddish stains and dried of food inside the bottom of the fridge. The bathroom floor had dark gray stains near and around the toilet and the corners of the floor. An observation on 08/17/25 at 12:08 PM of resident room [ROOM NUMBER] reflected the mini fridge had grayish stains inside the bottom of the fridge. A bedside table in the room had brownish stains along the bottom of the frame. The base of the toilet had brownish stains around the bolt. The bathroom floor had dark gray stains near and around the toilet and the corners of the floor. A night light, located on the bottom of a wall near the door entrance, had dark stains and dust on the cover. An observation on 08/17/25 at 12:11 PM of resident room [ROOM NUMBER] reflected the base of the toilet had brownish stains around the bolt. The bathroom floor had dark gray stains near and around the toilet and the corners of the floor. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The door frame had brownish spots along the bottom portion of the frame. An observation on 08/17/25 at 12:15 PM of resident room [ROOM NUMBER] reflected the base of the toilet had brownish stains around the bolt. The bathroom floor had dark gray stains near and around the toilet and the corners of the floor. The toilet in the bathroom had brownish stains on the inside bowl. An observation on 08/17/25 at 12:17 PM of resident room [ROOM NUMBER] reflected the air condition vents had [NAME] stains on and between the vents. The base of the toilet had brownish stains around the bolt. The bathroom floor had dark gray stains near and around the toilet and the corners of the floor. An observation on 08/17/25 at 12:23 PM of resident room [ROOM NUMBER] reflected the air condition vents had [NAME] stains on and between the vents. The base of the toilet had brownish stains around the bolt. The bathroom floor had dark gray stains near and around the toilet and the corners of the floor. The room floor had brownish stains near the bed and near a nightstand. In an interview on 08/19/25 at 12:10 PM, Housekeeper E stated she had been at the facility for 18 months. She stated she was assigned to clean the 300-hall. She stated they were to clean everything in the resident room, including the bathroom and shower stall. She stated the Housekeeping Supervisor had told her that the floor techs were to clean the air condition filters. She was shown pictures of the concerns observed in Resident room [ROOM NUMBER], #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, and #15, and she stated housekeeping was responsible for cleaning the areas mentioned. She stated not cleaning the areas could impact the resident's breathing. In an interview on 08/19/25 at 12:22 PM, the Housekeeping Supervisor stated he had been at the facility for 9 years. He stated the housekeeping staff used a checklist to clean the resident rooms. He was shown pictures of Resident room [ROOM NUMBER], #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, and #15. He stated they completed deep cleans daily and he spot checked the rooms. He stated he had the floor techs clean the air filters once a week. He stated he tried to strip the floors, but they had a challenging time getting the residents out of the room. He stated not thoroughly cleaning the resident rooms could impact their breathing. In an interview on 08/19/25 at 12:36 PM, the Administrator was shown pictures of the concerns observed in Resident room [ROOM NUMBER], #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, and #15. She stated she expected the resident rooms to be thoroughly cleaned. She stated not thoroughly cleaning the resident rooms could cause infections. Record 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 - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observations, interviews, and record reviews, the facility failed to ensure that residents' environment remained free of hazards as was possible for 1 (Resident #28) of twelve residents reviewed for accident hazard. The facility failed to ensure that a container of germicidal (substance that destroys germs and microorganism) wipes was not left inside Residents #28's room on 08/17/2025. This failure could prevent the residents from having an environment that was free from toxic chemicals. Findings include: Record review of Resident #28's Face Sheet, dated 08/18/25, reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with neoplasm (abnormal mass of tissues that could be cancerous or not) of the kidney and bone and sleep apnea (a sleep disorder where breathing is interrupted repeatedly during sleep). Record review of Resident #28's Comprehensive MDS Assessment (assessment used to determine functional capabilities and health needs), dated 07/17/2025, reflected the resident was cognitively intact (resident capable of normal cognition and needs little support) with a BIMS (screening tool used to assess cognitive status) score of 15. The Comprehensive MDS Assessment indicated that the resident had cancer and sleep apnea. Record review of Resident #28's Comprehensive Care Plan, dated 07/17/2025, reflected the resident had stage 4 carcinoma and sleep apnea. Observation and interview on 08/17/2025 at 9:59 AM revealed Resident #28 was in his bed, awake. It was observed that there was a container of germicidal wipes on the resident's bedside table. It was also observed that the container of germicidal wipes was near the CPAP (continuous positive airway pressure: machine used to deliver pressurized air through a mask to keep airways open) mask that was on the table. The resident said the container of germicidal wipes had been sitting on his table for some time. He said the staff would use it to clean some of the items inside his room. Observation and interview on 08/17/2025 at 10:12 PM, ADON B stated the container of germicidal wipes should not be inside Resident #28's room or any residents' room for that matter. She said it should not be close to any items used by the resident, like the CPAP mask, because the CPAP mask had contact with the resident's face when the resident was using it. She said it should be inside the cart the nurses' cart or the MAs' carts, locked. She said maybe, it was left by a CNA because they use it to clean the room. She said she would go to Resident #28's room and will get the container of germicidal wipes. She said the germicidal wipes had chemicals in it that could cause skin irritation that was why the staff used gloves when handling the wipes. She said it could also cause eye irritation and respiratory issues. She said it could affect the resident's condition because he was already immunocompromised. She said she would find out who left it inside the room and educate them. She said she would also initiate an in-service about not leaving anything that could be unsafe to the resident. She said she would also check the rooms of the other residents to see if there were any germicidal wipes left inside the room. In an interview on 08/17/2025 at 10:29 AM, CNA L stated he did not know who left the container of germicidal wipes inside Resident #28' room. He said he did not notice the container when he did his morning round. He said the container were usually inside the carts of the nurses or the MAs. He said it should be somewhere not accessible to the residents because they might touch or put it in their mouth and could cause harm to them because the wipes have chemicals on them. In an interview on 08/19/2025 at 11:28 AM, the Administrator stated the wipes should not be inside the residents' rooms because they were used to kill bacteria. She said if the wipes had chemicals in it that could be harmful. She said confused residents might touch it or visitors unknowingly thought the wipes were ordinary wipes that could be used to wipe the face. She said the expectation was that the staff would not leave the germicidal wipes inside the residents' room and that if they saw that somebody left it inside the room, they should get it and put it where it should be. She said she would coordinate with the DON and the ADONs to make sure nothing with chemicals were left inside the room or left (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	somewhere accessible to the residents. In an interview on 08/19/2025 at 11:43 AM, the DON stated the germicidal wipes should be locked inside the carts and not be inside the residents' rooms. She said it should be secured inside the carts so that the residents would not be able to access the wipes that had chemicals on them. She said she was not sure what chemical was on the wipes but considering the wipes were used to disinfect, then the wipes could be harmful to the residents. She said confused resident might get hold of the wipes and wipe their face and body that could result to irritations. She said the expectation was for the staff to be mindful and never leave the germicidal wipes inside the residents' room. She said she would do an in-service about not leaving anything harmful to the residents and would make sure that they understood the outcome if a resident got hold of the wipes. The DON said it should not be placed close to the CPAP mask as the CPAP mask was used by placing it in the face. Record review of the facility's policy MEDICATION STORAGE Pharmacy Services Policies and Procedures revised 04/17/2024 revealed POLICY . biologicals are stored safely, securely . the facility will store all drugs and biologicals in locked compartments . biological supply is only accessible to licensed nursing personnel, pharmacy personnel or authorized staff members . potentially harmful substances (e.g. cleaning supplies and disinfectants) are clearly identified and stored away).		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 three (Residents #2, #28, and #71) of twelve residents reviewed for respiratory care. 1. The facility failed to ensure an Oxygen in Use sign was placed outside Resident #2's room on 08/17/2025. 2. The facility failed to ensure Resident #28's CPAP (continuous positive airway pressure: machine used to deliver pressurized air through a mask to keep airways open) mask was properly stored when not in use on 08/17/2025. 3. The facility failed to ensure Resident #71's nasal cannula (flexible tube used to deliver oxygen to the nose through two prongs) was properly stored when not in use on 08/17/2025. These failures could place residents at risk for respiratory infection and not having their respiratory needs met. Findings included: 1. Record review of Resident #2's Face Sheet, dated 08/17/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with shortness of breath. Record review of Resident #2's Quarterly MDS Assessment, dated 06/03/2025, reflected the resident had moderate impairment (resident may need additional support and monitoring) in cognition with a BIMS score of 10. The Quarterly MDS Assessment indicated the resident was receiving oxygen therapy. Record review of Resident #2's Comprehensive Care Plan, dated 07/30/2025, reflected the resident was on oxygen therapy and one of the approaches was to administer oxygen as per order. Record review of Resident #2's Physician Order, dated 05/01/2025, reflected O2 at <u>2</u> liters per minute via nasal cannula. Observation on 08/17/2025 at 9:21 AM, revealed Resident #2 was in her bed with eyes closed. It was observed that the resident was on oxygen therapy at 2 liters per minute via nasal cannula. It was also observed there was no Oxygen in Use sign outside the resident's room. Observation and interview on 08/17/2025 at 9:41 AM, LVN F stated Resident #2 was using oxygen continuously. She said that if a resident was using oxygen, there should be an Oxygen in Use sign outside the resident's door so the staff and the visitors were aware oxygen was being used in the facility. She said the sign served as a reminder that they could not initiate any flame to prevent any untoward (unfavorable) incident such as fire and explosion. She went to the storage room, took a sign, and placed it outside the resident's room. 2. Record review of Resident #28's Face Sheet, dated 08/17/2025, reflected the resident was a [AGE] year-old male admitted on [DATE]. The resident was diagnosed with sleep apnea. Record review of Resident #28's Comprehensive MDS Assessment, dated 07/17/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident had sleep apnea and was using CPAP. Record review of Resident #28's Comprehensive Care Plan, dated 07/17/2025, reflected the resident had sleep apnea and one of the approaches was CPAP as ordered. Record review of Resident #28's Physician Order, dated 08/07/2025, reflected Noninvasive Ventilation via CPAP. Parameter set at 12 cm H2O on RA Via Medium sized Face Mask to be Administered with O2 2l/ml via NC QHS & PRN During Naps. Observation and interview on 08/17/2025 at 9:59 AM, revealed Resident #28 in his bed, awake. It was observed that a CPAP mask was on the resident's side table unbagged. The resident said the nurses would put it on at night and would take it off. He said he could take it off but it would be hard for him to put it on the table because the table was far from him. He said he was using the CPAP even before he was admitted to the facility. Observation and interview on 08/17/2025 at 10:12 AM, ADON B stated Resident #28 used a CPAP when he was sleeping and when he was taking a nap. She said the CPAP masks should be in a plastic bag when not in use to prevent cross contamination and respiratory infection. She went inside the resident's room and saw the CPAP mask on the side table. She said she would clean it and would put it in a bag. She said she would also find out who took it off and left it on the table so they could be reminded of bagging the CPAP mask. She said she would start an in-service about bagging the CPAP (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mask. 3. Record review of Resident #71's Face Sheet, dated 08/17/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with shortness of breath. Record review of Resident #71's Comprehensive MDS Assessment, dated 08/15/2025, reflected the resident had moderate impairment in cognition with a BIMS score of 09. The Comprehensive MDS Assessment indicated the resident was on oxygen therapy. Record review of Resident #71's Comprehensive Care Plan, dated 08/14/2025, reflected the resident had COPD (a chronic inflammatory lung disease that causes obstructed airflow from the lungs) and one of the approaches was oxygen as per order. Record review of Resident #71's Physician Order, dated 08/08/2025, reflected O2 at <u>2-4</u> liters per minute via nasal cannula Every Shift - PRN. Observation on 08/17/2025 at 9:27 AM, revealed Resident #71 was in her bed with eyes closed. An oxygen concentrator was observed at bedside with a nasal cannula connected to it. The nasal cannula was not bagged and was hanging on top of the oxygen concentrator. Observation and interview on 08/17/2025 at 9:34 AM, LVN F stated Resident #71 was on oxygen therapy, as needed. She went inside the resident's room and saw the nasal cannula hanging on top of the oxygen concentrator. She said the nasal cannula, should be bagged when the resident was not using them to prevent transfer of microorganisms that could eventually cause infection. She disconnected the nasal cannula and said she would get a new one and would place them in a bag. She said she did notice that the nasal cannula was not bagged when she did her morning round. In an interview on 08/19/2025 at 6:41 AM, ADON A stated it was her fault there was no Oxygen in Use outside Resident #2's room because she was the one responsible for checking who were the residents using oxygen and then placing the sign outside the rooms of resident using oxygen. She said the purpose of the sign was to remind the staff and the visitors not to light a cigarette or even a candle because oxygen was being used in the facility. She said nasal cannula should be stored properly inside a plastic bag if the residents were not using them to prevent respiratory infections or respiratory discomforts. She said the staff were responsible for ensuring all the breathing paraphernalia were clean every time the residents used them. She said the expectation was for the staff to be mindful and bag the nasal cannula and to check if there was an Oxygen in Use sign outside the door of residents that were using oxygen. She said she would start an in-service about oxygen administration. In an interview on 08/19/2025 at 7:16 AM, the DON stated the nasal cannula and the CPAP mask should be inside a plastic bag when not in use, and not just hanging around or on top of the table, to maintain its cleanliness as well as its patency. She said bagging the nasal cannula and the CPAP mask were important to prevent development of infections. She said if a resident was using oxygen, there should be an Oxygen in Use sign outside the door. She said the sign for oxygen use was to remind the staff and visitors to be careful not to cause any ignition that could cause fire. She said she was responsible for making sure the staff were bagging the nasal cannula and the CPAP mask and that they were placing a sign outside the door. She said she would re-educate the staff about the issues discussed and her expectations was that the staff would understand the in-services and would put them in practice. In an interview on 08/19/2025 at 7:32 AM, the Administrator stated everything that the residents were using for their respiratory issues should be kept clean to prevent cross contamination and respiratory infection. She said there should be a sign outside the door if a resident was using oxygen to avert any untoward incident such as fire. She said the expectation was that the staff would be compliant with the policies. She said she would coordinate with the DON and the ADONs to provide additional in-services and monitor their compliance. Record review of the facility's policy OXYGEN THERAPY Respiratory Policies and Procedures, dated 02/24/2024, revealed PROCEDURES . C. Check the patient's/resident's room to make sure it's safe for oxygen administration, place oxygen precautions sign on the door of the patient's/resident's room. Record review of the facility's policy EQUIPMENT CHANGE SCHEDULE Respiratory Policies and Procedures, dated 02/12/2024, revealed place in clean, dry plastic bag		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals that met the needs of each resident for one of eight residents (Resident #3) reviewed for pharmaceutical services The facility failed to dispose of Resident #3's expired Duloxetine dated 11/17/2024. This failure could place residents at risk of not receiving the medication's full therapeutic benefits and the possible side effects of taking expired medications. Findings included: Record review of Resident #3's Face Sheet, dated 08/13/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with depression (persistent feeling of sadness or loss of interest). Record review of Resident #3s Comprehensive MDS Assessment, dated 06/03/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident had depression. Record review of Resident #3's Comprehensive Care Plan, dated 08/14/2025, reflected the resident had depression and was being treated with antidepressant medication to manage symptoms. Record review of Resident #3's Physician's Order, dated 05/09/2025, reflected Duloxetine HCl 30 MG Capsule delayed release particles, 1 CAPSULE BY MOUTH ONE TIME A DAY. Observation on 08/18/2025 at 12:11 PM, revealed an expired duloxetine for Resident #3 was inside the medication cart. The date on the container of the medication was 11/17/2024. In an interview on 08/18/2025 at 12:13 PM, MA G stated Resident #3 was just transferred to hall 100 and it was her first time administering her medications. She said the resident had a blister pack for her duloxetine and that was what she used when she gave her morning medication. She said the expired one should not be inside the cart so that staff administering the medication would not mistakenly use the expired one. She said the effectiveness of the medication already diminished when it was expired or there could be adverse reactions from the expired medication. She said she would audit her cart to make sure there was no expired medications. she said she was responsible in auditing the cart that she was using. Observation and interview on 08/18/2025 at 12:14 PM, revealed ADON A saw Resident #3's expired medication and stated that particular medication should not be inside the cart because the medication was already expired. She said the medication was not from their pharmacy and must have been brought from the hospital when she was admitted to the facility and was just placed inside the cart without checking the date. She said expired medication inside the carts could be erroneously used and could cause reduced effectiveness or adverse effects to the organs of the body. She said the nurses and medication aides were responsible in ensuring there were no expired medication inside the carts. She said the resident was transferred to her hall the Friday prior and her medications were also transferred with her. She said the transfer of the medications were usually done from nurse-to-nurse, then the medications would be given to the medication aide. She said there were four sets of eyes, but no one noticed that one of the medications was expired. She said it should have been caught when the medication was still on the other cart. She took the expired medication from the cart and said she would dispose of the medications. She said the expectation was for the staff to check the carts for anything expired. She said she would audit the carts and would start an in-service about the issue. In an interview on 08/19/2025 at 6:27 AM, MA H stated he would administer Resident #3's medication when the resident was still on the other hall. He said he was responsible for auditing the cart that he was using. He said he was not aware one of the medications was already expired. He said he never gave the resident a medication from the container. He said expired medication could harm the residents. In an interview on 08/19/2025 at 7:16 AM, the DON stated expired medications should not be kept inside the cart so it would not be used for the resident, purposely or accidentally. She said the risk could be that the potency of the medication was already less and there might be harmful effects when an expired (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication was used. She said she would tell the nurses and the medications aides to check all the carts for any expired medications. She would also ask the ADONs to check medication room just to be sure. She said she would start an in-service that no expired medication be inside the cart and said her expectation was for the staff to make sure that the carts would be audited and that expired medications were disposed accordingly. In an interview on 08/19/2025 at 7:32 AM, the Administrator stated the expectation was that there were no expired medications inside the carts and medication rooms and that the staff would be auditing the carts. She said she was not a clinician, but one thing she knew, expired medication cannot be used. She said she would coordinate with the DON and the ADONs regarding the expired medication. In an interview on 08/19/2025 at 12:41 PM, LVN K stated she did receive Resident #3 when she was transferred to her hall the Friday prior. She said she also received the resident's medication and handed them over to MA H. She said she could not remember if they were all blister packs or if there were containers with them. She said she should have inspected the medications given her to check if there were expired medications because it could harm the residents. Record review of the facility's policy MEDICATION MANAGEMENT PROGRAM Nursing Policies and Procedures, dated 01/15/2025, revealed Administering the Medication Pass . D. Checking for expiration dates and removing any expired products. Record review of the facility's policy MEDICATION STORAGE Pharmacy Services Policies and Procedures, dated 04/17/2024, revealed PROCEDURES . 12. Outdated, contaminated, or deteriorated medications . are immediately removed . disposed of according to procedures for medication destruction.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were free from significant medication errors for one (Resident #70) of eight residents reviewed for medication administration. The facility failed to ensure RN C would not crush or dissolve Resident #70's Venlafaxine extended-release medication on 08/18/2025. These failures placed residents at risk of not receiving the full benefit of the medication. Findings included: Record review of Resident #70's Face Sheet, dated 08/18/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with dysphagia (difficulty in swallowing). Record review of Resident #70's Comprehensive MDS Assessment, dated 07/28/2025, reflected the resident was cognitively intact with a BIMS score of 13. The Comprehensive MDS Assessment indicated the resident had a feeding tube. Record review of Resident #70's Comprehensive Care Plan, dated 07/28/2025, reflected the resident was at risk for aspiration due to presence of feeding tube and one of the approaches was to observe for signs of aspiration. Record review of Resident #70's Physician Order, dated 07/31/2025, reflected Enteral Feeding: Flush tube with 60 cc warm water before and after medication administration; 10 - 15 cc flush between each med. Record review of Resident #70's Physician Order, dated 07/29/2025, reflected RISK: choking, swallowing, aspiration, weight loss/gain, dehydration. Record review of Resident #70's Physician Order, dated 07/25/2025, reflected Venlafaxine 150 mg ER via gastric tube two times a day. Observation on 08/18/2025 at 7:28 AM, revealed RN C was about to administer Resident #70's medication via g-tube. She said she would be administering four medications for the resident. one of the medications she prepared was Venlafaxine 150 mg ER capsule. It was observed that the content of the capsule was in granules form. She poured water on all medications and stirred them with plastic spoon one by one. In an interview on 08/18/2025 at 8:57 AM, RN C stated she had a hard time with the last medication because the granules would not pass through the syringe. She said she tried to dissolve it but it would not dissolve completely. She said she would sometimes crush the medication so it would pass through the tube easier. She read the order for the medication and saw the medication was an extended release. She said extended-release medications should not be crushed or dissolved because the medication was designed to be released in an extended period of time. She said she did not notice that the order was extended release. In an interview on 08/19/2025 at 7:02, ADON B stated extended-release medications were not crushed or dissolved because it could result to the medication being released too early or large amount released at once. She said the medication could also lose its potency. She said she already called the doctor and requested for a crushable replacement for Venlafaxine 150 mg ER. She said the order should have been checked and the medication that could not be crushed or dissolved should have been caught. She said expectation was for the orders for medications be reviewed and see if all the medications were crushable and could be dissolved. She said she would start an in-service about the issue. In an interview on 08/19/2025 at 7:16 AM, the DON stated extended release could not be crushed or dissolved because the medication was intended to be released in an extended period of time. She said dissolving the medication could affect the absorption of the medication. The DON said she would check if the nurse already called the doctor to get an order for a crushable venlafaxine. She said whoever was administering the medications should read the order to ensure accurate medication preparation. She said proper preparation should be done to prevent a medication error. The DON said the expectation was for the staff not to dissolve extended-release medications. The DON concluded she would get on top of this issue, re-educate the staff, and conduct in-services. In an interview on 08/19/2025 at 7:32 AM, the Administrator stated she would let the nurse managers take the lead about administering extended-release medications via g-tube. She said the expectation was for whatever the procedure was in giving the medications, it should be followed to prevent any errors. Record review of the facility's policy MEDICATION MANAGEMENT PROGRAM Nursing Policies and (continued on next page)		

Department of Health & Human Services
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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procedures, dated 01/15/2025, revealed Administering the Medication Pass . F. Crush oral medications in accordance with facility policy.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the medications for eight (Residents #2, #3, #5, #7, #49, #60, #68, and #77) of twenty-one residents were stored properly in locked compartments or provided a safe and secured storage with limited access. 1. The facility failed to ensure Resident 2's zinc oxide (cream used to treat skin irritations, diaper rash, and other skin conditions) was not left on top of the resident's side table on 08/17/2025. 2. The facility failed to ensure Resident 3's zinc oxide was not left on top of the resident's side table on 08/17/2025. 3. The facility failed to ensure Resident 5's zinc oxide was not left on top of the resident's side table on 08/17/2025. 4. The facility failed to ensure Resident 7's Theraworx (medication used for muscle cramps) was not left on top of the resident's side table on 08/17/2025. 5. The facility failed to ensure Resident #49's triple antibiotics (medication used for skin tears) was not left inside the room on 08/17/2025. 6. The facility failed to ensure Resident 60's zinc oxide in a cup was not left on top of the resident's side table on 08/17/2025. 7. The facility failed to ensure Resident 68's zinc oxide in a cup was not left on top of the resident's side table on 08/17/2025. 8. The facility failed to ensure Resident 77's zinc oxide was not left on top of the resident's side table on 08/17/2025. These failures could place the residents at risk of accidental overdose or misuse of medications. Findings included: 1. Record review of Resident #2's Face Sheet, dated 08/17/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with depression. Record review of Resident #2's Quarterly MDS Assessment, dated 06/03/2025, reflected the resident had moderate impairment in cognition with a BIMS score of 10. The Quarterly MDS Assessment indicated the resident had depression and was incontinent for bladder. Record review of Resident #2's Comprehensive Care Plan, dated 07/30/2025, reflected the resident was at risk for pressure ulcer and one of the approaches was to use skin barrier cream for skin protection. Record review of Resident #2's Physician Order on 08/17/2025 reflected no order for zinc oxide. Observation on 08/17/2025 at 9:21 AM revealed Resident #2 was in her bed with eyes closed. A container of zinc oxide was observed on top of the resident's side table. 2. Record review of Resident #3's Face Sheet, dated 08/13/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with depression. Record review of Resident #3's Comprehensive MDS Assessment, dated 06/03/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident was incontinent for bladder and bowel. Record review of Resident #3's Comprehensive Care Plan, dated 08/14/2025, reflected the resident was at risk for pressure ulcer due to incontinence and one of the approaches was to use skin barrier cream for skin protection. Record review of Resident #3's Physician Order on 08/17/2025 reflected no order for zinc oxide. Observation on 08/17/2025 at 9:15 AM, revealed Resident #3 was in her bed with eyes closed. A container of zinc oxide was observed on top of the resident's side table. 3. Record review of Resident #49's Face Sheet, dated 08/17/2025, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with muscle weakness. Record review of Resident 49's Comprehensive MDS Assessment, dated 08/14/2025, reflected the resident had a moderate impairment in cognition with a BIMS score of 11. The Comprehensive MDS Assessment indicated the resident was incontinent for bladder and bowel. Record review of Resident #49's Comprehensive Care Plan, dated 08/15/2025, reflected the resident was at risk for pressure ulcer due to decreased immobility and one of the approaches was to use skin barrier cream for skin protection. Record review of Resident #49's Physician Order on 08/06/2025 reflected, Daily Wound Treatment: Right Buttock, Cleanse with NS, PAT & DRY, Cover with dry dressing daily & PRN. Observation on 08/17/2025 at 9:31 AM, revealed Resident #49 was not inside her room. A tube of (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	triple antibiotics was observed on top of the resident's side table. 4. Record review of Resident #77's Face Sheet, dated 08/17/2025, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with muscle weakness. Record review of Resident 77's Comprehensive MDS Assessment, dated 07/21/2025, reflected the resident had a moderate impairment in cognition with a BIMS score of 12. The Comprehensive MDS Assessment indicated the resident was incontinent for bladder. Record review of Resident #77's Comprehensive Care Plan, dated 07/30/2025, reflected the resident was at risk for pressure ulcer due to decreased immobility and one of the approaches was to use skin barrier cream for skin protection. Record review of Resident #77's Physician Order on 08/17/2025 reflected no order for zinc oxide. Observation on 08/17/2025 at 9:19 AM, revealed Resident #77 was in her bed with eyes closed. A container of zinc oxide was observed on top of the resident's side table. In an interview on 08/17/2025 at 9:41 AM, LVN F stated zinc oxide and the triple antibiotics were a form of medication because zinc oxide was used to prevent skin irritation and triple antibiotics was used to treat issues like skin tears. She said both zinc oxide and the triple antibiotics should not be inside the room or should be stored where they were not accessible to the residents. She said she did notice the medications when she did her morning round. She said she was not aware how long the medications were inside the rooms of the residents. She went inside Residents #2, #3, #49, and #77's rooms and removed the zinc oxides and the triple antibiotics. She said confused residents might mistakenly consume them and might cause adverse reactions such as allergy and stomach upset. 5. Record review of Resident #5's Face Sheet, dated 08/17/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with irritant contact dermatitis (inflammation of the skin). Record review of Resident #5's Comprehensive MDS Assessment, dated 07/17/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident had moisture associated skin damage. Record review of Resident #5's Comprehensive Care Plan, dated 06/17/2025, reflected the resident had a pressure ulcer and one of the approaches was to use skin barrier for protection. Record review of Resident #5's Physician Order, dated 08/12/2025, reflected Apply House Barrier Cream to buttocks as needed. Observation and interview on 08/17/2025 at 9:50 AM, revealed Resident #5 was in her bed, awake. It was observed that a tube of zinc oxide was on the resident's overbed table and was on a tray along with her snacks. She said the zinc oxide had been on the tray for quite some time. She said she was not sure if the staff saw it or not. In an interview on 08/17/2025 at 10:12 AM, ADON B said zinc oxide and triple antibiotics were medications because they were used to prevent or treat skin issues. She said those medications should not be left or stored inside the residents' rooms because the residents might administer or use them incorrectly that could result to adverse reactions. She said the medicated creams and ointments should be stored in the cart because it had chemicals that could be toxic when consumed. She said the staff could also secure them in drawers or somewhere the residents could access them. She said there should be physician orders for such medications as well. She said the expectation was for the staff to be compliant with the policies regarding medication storage to ensure that the residents would not have any access to them. She said she would go to Resident #5's room to get the zinc oxide and then would start an in-service about medication storage. 6. Record review of Resident #7's Face Sheet, dated 08/17/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with pain disorder and idiopathic neuropathy. Record review of Resident #7's Comprehensive MDS Assessment, dated 08/14/2025, reflected the resident had severe impairment in cognition with a BIMS score of 03. The Comprehensive MDS Assessment indicated the resident received scheduled pain medication. Record review of Resident #7's Comprehensive Care Plan, dated 06/17/2025, reflected the resident had nerve pain to wrist and one of the approaches was to administer pain medication as ordered. Record review of Resident #7's Physician Order on 08/17/2025 reflected no order for Theraworx (medication used for muscle cramps). Observation on 08/17/2025 at 11:35 AM revealed Resident #7 was not inside the room. A Theraworx foam spray was (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	observed on the resident's side table. Observation on 08/18/2025 at 9:51 AM revealed the Theraworx spray was still on Resident #7's side table in plain view. Observation and interview on 08/18/2025 at 10:10, LVN E she did not see the Theraworx foam spray when she did her morning round. She said it was a form of medication because it provided relief during muscle cramps. She talked to Resident #7 and said she would get the foam spray and would put it in the cart. She also told the resident that she would get an order for the Theraworx. She said the said medication should not be inside the room because the confused resident might consume it or other confused residents might go inside the room and consume it as well. She said sometimes the family would bring some medications and would not inform them. In an interview on 08/18/2025 at 10:56 AM, Resident #7 was asked where the medication that was taken by LVN E came from, the resident did not reply. 7. Record review of Resident #60's Face Sheet, dated 08/17/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with hemiplegia and hemiparesis. Record review of Resident 60's Comprehensive MDS Assessment, dated 06/30/2025, reflected the resident had a severe impairment in cognition with a BIMS score of 07. The Comprehensive MDS Assessment indicated the resident had a stroke. Record review of Resident #60's Comprehensive Care Plan, dated 06/25/2025, reflected the resident was at risk for pressure ulcer due to decreased mobility and one of the approaches was to use skin barrier for protection. Record review of Resident #60's Physician Order on 08/17/2025 reflected no order for zinc oxide. Observation on 08/17/2025 at 9:51 AM, revealed Resident #60 was not inside the room. It was observed that some cream on a cup was at the resident's bedside table. 8. Record review of Resident #68's Face Sheet, dated 08/17/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with overactive bladder. Record review of Resident 68's Comprehensive MDS Assessment, dated 07/01/2025, reflected the resident had a severe impairment in cognition with a BIMS score of 07. The Comprehensive MDS Assessment indicated the resident was incontinent for bladder and bowel. Record review of Resident #68's Comprehensive Care Plan, dated 07/01/2025, reflected the resident was at risk for skin breakdown due to overactive bladder and one of the approaches was to administer medications as ordered. Record review of Resident #68's Physician Order, dated 06/17/2025, reflected Barrier cream to perineum (area between the legs) after each incontinent episode. Observation on 08/17/2025 at 9:44 AM revealed Resident #68 was not inside the room. It was observed that some cream on a cup was at the resident's bedside table. Observation and interview on 08/17/2025 at 10:29 AM, CNA L stated he did not notice the cups inside Resident #60 and Resident #68's room until his attention was called. He said the cream inside the cups was zinc oxide used when they were changing the residents. He said the cups should have been thrown away after it was used so the resident would not be able to get the cups. He said the cream might be harmful to the residents. He took the cups and threw them in the trash can. In an interview on 08/19/2025 at 6:41 AM, ADON A stated the zinc oxides, TAO, and Theraworx were medications and should not be within reach of the residents because the resident might accidentally ingest them. She said the creams, ointment, and foam had chemicals that could be toxic when ingested by anybody. She said confused residents might mistake them as toothpaste and put them in their mouth. She said the expectation was for the staff to put the said medications where the resident could not reach it, like in the carts. She said she would do an in-service pertaining to medication storage. In an interview on 08/19/2025 at 7:16 AM, the DON stated zinc oxide was used during incontinent care to prevent skin irritation, TAO was used for treatment of skin tears or abrasions, and Theraworx foam was used to provide relief during muscle cramps. She said the medications should be secured and should not be accessible to the residents because they could be harmful to the resident if they accidentally consumed them or put them in their face or eyes. She said they should be placed inside the drawer of the side tables after use. She said if the resident or a visitor ingested it, there could be adverse reactions, especially if somebody who accidentally ingested the medications were allergic to the medications. She said the expectation was the medicated cream, ointment, and foam used for (continued on next page)		

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	treatment be placed inside the carts to secure it and that the staff would check the residents' room for medications. She said she would do an in-service making sure no medicated cream, ointment, and foam were accessible to the residents. In an interview on 08/19/2025 at 7:32 AM, the Administrator stated the expectation was that the barrier cream, triple antibiotics, and the Theraworx foam should not be inside the room or within reach of the residents to prevent accidental consumption that could result to adverse reactions like allergy, stomach upset, and irritations. She said she would coordinate with the ADONs and the DON to educate the staff about the matter. Record review of the facility's policy MEDICATION STORAGE Pharmacy Services Policies and Procedures, dated 04/17/2024, revealed POLICY . 1. Medications and biologicals are stored safely, securely . the facility will store all drugs and biologicals in locked compartments . 2. The medications and biological supply is only accessible to licensed nursing personnel, pharmacy personnel or authorized staff members.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for the facility's only kitchen, reviewed for food and nutrition services. 1. The facility failed to ensure foods in the freezer was concealed from air borne contaminants. 2. The facility failed to ensure food in the walk-in cooler and freezer were labeled and dated when stored. 3. The facility failed to discard molded food in the walk-in cooler. 4. The facility failed to ensure storage bins in the dry storage area were thoroughly cleaned. These failures could place residents at risk for cross contamination and air-borne illnesses. Findings include: Observations on 08/17/25 from 9:16 AM to 9:26 AM in the facility's only kitchen revealed: One zip lock bag of fish filets, located in the walk-in cooler, was not labeled with the date stored. One large container of thick substance, located in the walk-in cooler was not labeled and dated. One large bag of diced bell peppers, located in the walk-in cooler, was not labeled with the date stored. One large box of frozen lima beans, located in the freezer, was not concealed from air-borne contaminants. One large box of frozen biscuits, located in the freezer, was not concealed from air-borne contaminants. One bag of hash browns, located in the freezer, was not labeled with the date stored. Two storage bins containing sugar and flour, located in the dry storage area, had dirt stains on the outside and near the opening of the containers. One large storage bin of corn meal, located in the dry storage area, had brown stain along the inside walls of the container. One large storage bin of salt, located in the dry storage area, had a brown patch in the salt, which was later described as dried up water mixed into the salt. One large plastic bottle of sweet-and-sour sauce observed with visible mold growth around the lid and exterior of the bottle. In an interview on 08/18/25 at 11:23 AM, the Dietary Manager was advised of the findings in the kitchen. She stated the cooks label and date the food in the freezer and the walk-in cooler and Dietary Aides label and date the food in the dry storage area. She stated she normally inspect the area every morning but did not get around to doing in that morning. She stated she had a new cook, and she was trying to her to ensure that foods are labeled and dated and stored properly. She stated she had the containers cleaned at least once a week and it was just overlooked. She stated the foods in the freezer should have been covered to avoid freezer burn. She stated the risk of not addressing these concerns could result in residents getting sick. In an interview on 08/18/25 at 11:55 AM [NAME] M, was advised of the findings in the kitchen. She stated staff were trained to regularly sanitize bottles and containers, including wiping them down during line checks and before closing. She stated she understood any sign of mold or buildup, even if the contents appear unaffected, warranted immediate disposal. She stated she routinely checked the condition of frequently used squeeze bottles and condiment containers throughout the day. She was shown a picture of the container, which contained mold around the opening and stated she did not notice it and said it was an oversight. She stated the contaminated item would be thrown away immediately. She stated the need of maintaining a clean and safe food preparation environment to avoid residents getting sick. In an interview on 08/18/25 at 12:25 PM [NAME] H was advised of the findings in the kitchen. She stated food containers were wiped down regularly and labeling and dating food were part of the expected routine. She stated if any staff member observed mold or residue on a bottle, they were expected to discard the item immediately to avoid any risk to residents. She was shown the photo of the molded bottle, and she stated she hadn't noticed the issue. She stated it was an oversight and stated the bottle would be thrown out. She stated the need of food safety procedures when storing food. In an interview on 08/19/25 at 12:36 PM, the Administrator was shown pictures of the concerns observed in the kitchen area. She stated she expected the kitchen staff to follow the policy on proper food and storage and kitchen sanitation. She reinforced the importance of following established food safety policies, particularly around labeling, dating, and the general handling of kitchen containers. She emphasized (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that lapses in sanitation can lead to contamination, which poses a direct health risk to residents not only through illness but also by potentially affecting their nutritional intake. Record review of the facility's policy on NUTRITION ORIENTATION & COMPETENCY POLICIES AND PROCEDURES, FOOD STORAGE (07/21/2023), revealed If food is not stored properly, chances are that it will spoil quickly. Remember these pointers for storage: Label and date new food items removed from their original containers. Always cover, label and date leftovers that are to be stored. They should be date marked with the use by date. Keep all containers of food tightly covered. Keep all storage areas clean and dry. Record review of the U.S. Food and Drug Administration (FDA) Code (2022) revealed, Food shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306.		

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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** Based observation, interview, and record review the facility failed to establish and 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 five (Resident #23, #28, #48, #70, and #71) of twelve residents reviewed for infection control. 1. The facility failed to ensure CNA J wore a gown while fixing Resident #23's beddings, who had a catheter (flexible tube inserted into the bladder to remove the urine), on 08/17/2025. 2. The facility failed to ensure RN D placed a cap (green disinfecting caps) Resident 28's PICC line (long, flexible tube inserted into the vein used for administering intravenous medications) on 08/17/2025. 3. The facility failed to ensure LVN E performed hand hygiene and sanitized the overbed table before performing Resident #48's wound care and sanitized the scissors after getting it from her pocket on 08/18/2025. 4. The facility failed to ensure RN C wore a gown while dressing Resident #70, who had a g-tube (gastrostomy feeding tube: a tube that is surgically inserted through the skin of the belly and into the stomach), on 08/18/2025. 5. The facility failed to ensure LVN E performed hand hygiene before providing care to Resident #71 on 08/18/2025. 6. The facility failed to ensure CNA I performed hand hygiene while providing incontinent care to Resident #71 on 08/18/2025. These failures could place residents at risk of cross-contamination and development of infections. Findings included: 1. Review of Resident #23's Face Sheet, dated 08/17/2025, reflected the resident was a [AGE] year-old female admitted on the facility on 08/19/2024. The resident 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 #23's Comprehensive MDS Assessment, dated 06/20/2025, reflected the resident had a severe impairment (requires significant assistance and support in daily life) in cognition with a BIMS score of 00. The Comprehensive MDS Assessment indicated the resident had an indwelling catheter (device that drains urine from the urinary bladder). Review of Resident #23's Comprehensive Care Plan, dated 06/11/2025, reflected the resident required an indwelling catheter and one of the interventions was provide catheter care as scheduled. The Comprehensive Care Plan indicated the resident was on enhanced barrier precaution related to Foley catheter (device used to help drain urine from bladder). Record review of Resident #23's Physician Order, dated 08/20/2024, reflected Foley catheter care every shift. Record review of Resident #23's Physician Order, dated 06/25/2024, reflected Enhanced Barrier Precaution every shift. Observation on 08/17/2025 at 1:13 PM revealed CNA J was inside Resident #23's room and was fixing the resident's beddings. The resident was observed to have a catheter and there was a signage outside the room that the resident required enhanced barrier precaution during changing linens. In an interview on 08/17/2025 at 1:17 PM, CNA J stated Resident #23's family member asked her to fix the resident's bed. She said when she entered the room, the linens were already stripped and all she did was to put on the new beddings. She said she should have worn a gown and a pair of gloves when she was fixing the bedding because the resident was on EBP and the signage outside the room clearly stated to use EBP when changing the linens. She said the resident was not in the bed but she could introduce germs from her scrubs or she could get germs from the bed and transfer it to another resident that she would later have contact. 2. Record review of Resident #28's Face Sheet, dated 08/18/25, reflected the resident was a [AGE] year-old male admitted on [DATE]. The resident was diagnosed with local infection of the skin and subcutaneous (located under the skin) tissue. Record review of Resident #28's Comprehensive MDS Assessment, dated 07/17/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated that the resident had local infection of the skin and subcutaneous tissue. Record review of Resident #28's Comprehensive Care Plan, dated 08/07/2025, reflected the resident required IV medication for wound infections and one of the approaches was to administer medications: ABT. Record review of Resident #28's Physician Order, (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dated 08/07/2025, reflected IV CEFEPIME 1 GM/50 ML. 1 GM IV EVERY SIX HOURS ACTIVATE AND INFUSE IV CEFEPIME 1 GM OVER 30MINS (TOTAL VOLUME 50 ML WITH RATE OF 100 ML/HR). Observation and interview on 08/17/2025 at 9:59 AM, revealed Resident #28 in his bed, awake. It was observed that the resident had a PICC line to left upper arm. The resident said he had a PICC line because he was receiving an antibiotic for his skin infection. Observation at 08/18/2025 at 8:20 AM, revealed RN C was about to administer Resident #28's antibiotics via PICC line to his left upper arm. The end of the PICC line was not capped and was touching the resident's hospital gown. In an interview on 08/18/2025 at 8:44 AM, RN C stated she usually put a green cap on Resident #28's PICC line to prevent cross contamination. She said she did not see any green cap on the resident's side table that was why she was not able to put one on. She said she did sanitize the port of the PICC line before flushing it but since it was laying on the resident's hospital gown, one would never know if something already crept inside before it was sanitized. She said the best practice was to put a cap on the PICC line after medication administration. In an interview on 08/19/2025 at 6:33 AM, RN D said she would administer Resident #28's 2 AM antibiotics. She said she should cover the PICC once the medication was done to prevent cross contamination and infection because the resident already had an infection that was why he was receiving an antibiotic and not capping the end of the PICC line could only introduce another form of infection to the resident. 3. Record review of Resident #48's Face Sheet, dated 08/18/2025, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with injury of unspecified body region and parkinsonism (movement disorder). Record review of Resident #48's Quarterly MDS Assessment, dated 07/23/2025, reflected the resident had a severe impairment in cognition with a BIMS score of 00. The Quarterly MDS Assessment indicated the resident had Parkinson's disease (movement disorder). Record review of Resident #48's Quarterly Care Plan, dated 06/11/2025, reflected the resident had seizure like activity and was at risk for injury and one of the interventions was to keep the resident safe by keeping clutter away. Record review of Resident #48's Physician Order, dated 08/10/2025, reflected Treatment order for skin tear right knee. Cleanse wound with normal saline apply xeroform and cover with dry dressing daily until resolved. Observation on 08/18/2025 at 9:51 AM, LVN E was about to do Resident #48's wound care. She prepared normal saline pink bullets, 4 by 4 dressing, gauze, and xeroform (dressing used to cover wounds). She went inside the resident's room and placed the things that she prepared for wound care on top of the resident's overbed table. She did not sanitize the table. She put on a gown and a pair of gloves and proceeded with wound care. She did not do hand hygiene before putting on a pair of gloves. After cleaning the wound, she took a pair of scissors from her pocket and cut the xeroform to the desired size. She did not sanitize the pair of scissors, that was from her pocket, before cutting the xeroform. After placing the xeroform on the wound, she covered it with the 4 by 4 dressing. She cleaned the overbed table and washed her hands. In an interview on 08/18/2025 at 10:10 AM, LVN E stated she should have sanitized the table before she placed the things needed for wound care on it to make sure that the dressing, gauze, and xeroform were clean when applied to the wound. She said she should have sanitized the scissors before cutting the xeroform because it came from her pocket. She said she sanitized it before putting it in her pocket but since her pocket might be dirty then the pair of scissors was considered dirty again. She said her actions could contribute to cross contamination and development of infection. 4. Record review of Resident #70's Face Sheet dated 08/18/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with dysphagia (difficulty in swallowing). Record review of Resident #70's Comprehensive MDS Assessment, dated 07/28/2025, reflected the resident was cognitively intact with a BIMS score of 13. The Comprehensive MDS Assessment indicated the resident had a feeding tube. Record review of Resident #70's Comprehensive Care Plan, dated 07/28/2025, reflected the resident was at risk for aspiration due to presence of feeding tube and one of the approaches was to observe for signs of aspiration. The Comprehensive Care Plan indicated the resident was on enhanced barrier precaution related to (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	feeding tube. Record review of Resident #70's Physician Order, dated 07/25/2025, reflected The resident is on Enhanced Barrier Precautions related G-Tube. Observation and interview on 08/18/2025 at 7:28 AM revealed RN C was about to administer Resident #70's medication via g-tube. She said she would prepare the resident first. She went inside the room and assisted the resident with clothes. The resident had a g-tube and there was a sign outside the door that the resident required EBP during dressing. In interview on 08/18/2025 at 8:57 AM, RN C stated she should have worn a gown when she was assisting Resident #70 with her clothes because the resident had a feeding tube. She said she the EBP was implemented to prevent transfer of microorganism from one resident to another, especially for those residents that had feeding tubes. 5. Record review of Resident #71's Face Sheet, dated 08/17/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with shortness of breath. Record review of Resident #71's Comprehensive MDS Assessment, dated 08/15/2025, reflected the resident had moderate impairment in cognition with a BIMS score of 09. The Comprehensive MDS Assessment indicated the resident was on oxygen therapy. Record review of Resident #71's Comprehensive Care Plan, dated 08/14/2025, reflected the resident had COPD and one of the approaches was oxygen as per order. Observation on 08/18/2025 at 9:37 AM revealed LVN E was called by Resident #71's family member and stated the resident seems to need oxygen. LVN E went inside the room, put on a pair of gloves but did not perform hand hygiene before putting on the pair of gloves. She placed the nasal cannula on the resident's nose and then said the oxygen concentrator seems to not be working. She told the family member that she would get another oxygen concentrator. She went out of the room and came back with another oxygen concentrator. She put on a pair of gloves and did not perform hand hygiene again. She connected the nasal cannula on the oxygen concentrator and put on the nasal cannula on the resident. In an interview on 08/17/2025 at 9:41 AM, LVN E stated she should have washed her hands or sanitized them before putting on a pair of gloves. She said hand hygiene was being done to make sure that the hands were clean before touching the clean pair of gloves. She said hand hygiene was being implemented to prevent transfer of microorganism and development of infections. 6. Record review of Resident #71's Face Sheet, dated 08/17/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with senile degeneration of brain. Record review of Resident #71's Comprehensive MDS Assessment, dated 08/15/2025, reflected the resident had moderate impairment in cognition with a BIMS score of 09. The Comprehensive MDS Assessment indicated the resident was incontinent for bowel and bladder. Record review of Resident #71's Comprehensive Care Plan, dated 08/14/2025, reflected the resident was incontinent for bowel and bladder and one of the approaches was provide incontinence care after each incontinent episode. Observation on 08/18/2025 at 9:16 AM, revealed Resident #71 had just finished bowel movement and CNA I was about to put the resident's brief on but the resident asked again for her bed pan. CNA I went to the bathroom and got the resident's bed pan and placed it under the resident. When the resident said she was done, CNA I took the bed pan. She removed her gloves and put on a new pair of gloves from her pockets. She did not do hand hygiene before putting on a new pair of gloves. She cleaned the resident again. After cleaning the resident, she removed her gloves and put on a new pair of gloves. She did not perform hand hygiene before putting on the new pair of gloves and the gloves were from her pocket again. She took the brief from the resident's side, placed it under the resident, and fixed it. She removed her gloves and washed her hands. In an interview on 08/18/2025 at 9:25 AM, CNA I stated hand hygiene was important to prevent cross contamination and to prevent infection. She said she did hand hygiene before and after Resident #71's incontinent care but did not sanitized her hands when she changed her gloves. She said sanitizing the hands in between changing of gloves was done to make sure the hands were clean before touching the gloves. She said she should have taken a box of large gloves instead of hoarding them in her pocket to make sure that the gloves she would be using were clean. She said her pocket might be dirty because she would sometimes put her keys in it. She said she would be mindful the next time she does incontinent care (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to do hand hygiene in between changing of gloves and not to put the gloves inside her pocket. In an interview on 08/19/2025 at 6:41 AM ADON A at 6:41 AM, ADON A stated staff must perform hand hygiene before doing any care, must sanitize their hands before putting on a new pair of gloves, must not put their gloves on their pockets, must sanitize the table and the scissors before doing wound care, must place a cap at the end of the PICC line after medication administration, and must wear a gown when EBP was required. She said deviation from the said procedures could result to cross contamination and development of infection. She said the expectation was for the staff to be mindful and compliant with the policy of infection control. She said she would start an in-service about infection control. In an interview on 08/19/2025 at 7:02 AM, ADON B stated staff must wash their hands before and after any care, should sanitize their hands when changing their gloves, should not put gloves in the pockets, should make sure that the table was clean and the scissors to be used was sanitized, should place a green cap on the PICC line, and worn a gown if the resident had a catheter and a g-tube. she said all the issues discussed could contribute to cross contamination and development of probable infection. She said the expectation was for the staff to be diligent in caring for the residents and would not add another issue to their existing conditions. She said she would start an in-service about infection control and would closely monitor the staffs' adherence to the policy of infection control. In an interview on 08/19/2025 at 7:16 AM, the DON stated hand hygiene was the most effective way to prevent cross contamination and spread of infection. She said hand hygiene should be done before any care and before putting on a pair of gloves. She said gloves should not be placed on the staff's pockets because there was no assurance that their pockets were clean. She said, basically, the gloves from the pockets were deemed dirty. She said everything that would be used for wound care, like the table and the scissors should be sanitized to keep the dressing and xeroform clean when applied to the wound. She also said that the end of the PICC line should be capped to maintain a close circuit. She said the staff do sanitize the port before medication administration but what if the microorganisms already snuck inside the PICC line port. She said the purpose of the antibiotics being given was defeated. She said when a resident was on EBP, staff should wear a gown and a pair of gloves when handling the resident or the resident's beddings. She said the expectation was for the staff to be mindful with what they were doing to protect the residents from all kinds of infections. She said she would do an in-service pertaining to infection control focusing on all the issues discussed. She said she would closely monitor the staff with their compliance to the policy of infection control. In an interview on 08/19/2025 at 7:32 AM, the Administrator stated the expectation was for the staff to adhere to the policy of infection control. She said hand hygiene should be done, the PICC line should be capped, no gloves in the pockets, sanitize the table and scissors, and wear a PPE if the resident required EBP. She said the staff should always make sure that they were aware that their actions could cause infections. She said she would coordinate with the DON and ADONs to do an in-service about infection control and for them to monitor closely, and make sure the staff understood the in-services to be done. Record review of the facility's policy, HAND HYGIENE/HANDWASHING Infection Prevention and Control Policies and Procedures, dated May 15, 2023, revealed, POLICY: Proper hand hygiene/hand washing technique will be accomplished at all times that handwashing is indicated . Hand Hygiene/Hand washing is the most important component for preventing the spread of infection . PROCEDURES . 1. Hand hygiene/hand washing is done . Before . A. Before patient/resident contact . F. Before performing an aseptic task . After . A. After contact with soiled or contaminated articles . H. H. After removal of medical/surgical or utility gloves. Record review of the facility's policy, Incontinence Management, undated, revealed, Remove and discard gloves . Perform hand hygiene. Record review of the facility's policy, TRANSMISSION BASED/STANDARD PRECAUTIONS, AND ENHANCED BARRIER PRECAUTIONS Infection Prevention and Control Policies and Procedures, dated May 15, 2023, revealed, EBP will be implemented for all residents with . urinary catheter . feeding tube . EBP will be implemented during the following high contact-resident care activities . 1. Dressing . 5. Changing linens. Record review of (continued on next page)		

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the facility's policy Peripherally Inserted Central Catheter Use, undated revealed, Place a disinfectant-containing end cap on the needleless connector.		

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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** 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 1 of 8 residents (Resident #50) reviewed for dignity. CNA S failed to assist feed Resident #50 at eye level when assisting the resident with her lunch. This failure placed residents at risk of not having their right to a dignified existence maintained. Findings included: Record review of Resident #50's Face Sheet, dated 08/18/25, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #50 had diagnoses of severe protein-calorie malnutrition, and dysphagia (difficulty swallowing). Record review of Resident #50's Quarterly MDS Assessment, dated 07/15/25, reflected Resident #50 had severe cognitive impairment with a BIMS score of 3. The Quarterly MDS Assessment reflected the resident required total assistance for feeding. Record review of Resident #50's Comprehensive Care Plan, dated 08/14/25, did not reflect a care plan for feeding assistance. Record review of Resident #50's Physician Order, dated 08/18/25, reflected Eating with assist of X 1 Person. In an Observation and interview on 08/18/25 at 9:05 AM, CNA S was observed feeding Resident #50 her lunch, while the resident was lying in bed. CNA S was observed standing over the resident, not at eye level, feeding the resident. She was asked how she should be feeding the resident, and she stated the resident should be sitting up at a 45-degree angle. She was asked if she should be eye level with the resident and she stated she was able to see the resident's eyes, and she found no concerns with her standing over the resident while feeding her. In an interview on 08/18/25 at 9:07 AM, RN S was advised of CNA S being observed feeding Resident #50 while she was standing over the resident. RN S stated staff should ensure the resident was sitting up and staff should be at eye level to ensure the resident was not choking and for the resident's dignity. In an interview on 08/18/25 at 9:10 AM, the DON was advised of CNA S being observed feeding Resident #50 while she was standing over the resident. The DON stated staff was to be at eye level while feeding the residents because it was for the resident's dignity. The DON stated she was going to in-service the CNA on the protocol for feeding residents. Record review of facility's policy, ACTIVITIES OF DAILY LIVING, OPTIMAL FUNCTION, dated 05/05/03, revealed Activities of daily living (ADLs), refer to tasks related to personal care including, grooming, dressing, oral hygiene, transfer, bed mobility, eating, bathing and communication system. POLICY: The Facility provides care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. The Facility provides necessary care to all residents that are unable to carry out activities of daily living on their own to ensure they maintain proper nutrition, grooming, and hygiene. Facility staff develop and implement interventions in accordance with the resident's assessed needs, goals for care, preferences and recognized standards of practice that address the identified limitations in ability to perform ADLs. Record review of facility's policy, Quality of Life - Dignity & Privacy, dated August 2009, revealed Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, privacy, respect and individuality. Residents shall be treated with dignity and respect, and resident privacy will be protected. Residents will be assisted in maintaining and enhancing his or her self- esteem and self-worth.		

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure resident is assessed using the standardized Quarterly Review assessment tool no less than once every 3 months between comprehensive assessments for one of six residents (Resident #54) reviewed for Resident Assessments. The facility failed to ensure Resident #54 completed a Quarterly Review assessment within 3 months of the previous completed on 04/18/25. This failure could place residents at risk of their needs not being met and addressing any potential change in condition. Findings include: Record review of Resident #54's Face Sheet, dated 08/19/25, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #54 had diagnoses of Dysphagia (difficulty swallowing), and Cerebral Infarction (stroke). Record review of Resident #54's Quarterly MDS Assessment, dated 04/18/25, reflected Resident #54 had an intact cognitive response with a BIMS score of 14. The Quarterly MDS Assessment reflected the resident required total assistance for ADL care and a diagnosis of muscle weakness. Record review #54's Comprehensive Care Plan, dated 08/12/25, reflected the resident's last care plan conference occurring on 05/23/25. Record Review of Resident #54's Quarterly MDS Assessment, dated 04/18/25, reflected Resident #54 had an assessment due date of 07/19/25, and it was not completed. In an interview on 08/19/25 at 9:50 AM, MDS Nurse C stated a Quarterly MDS Assessment was not completed for Resident #54. She stated she did not know how it was overlooked. She stated the Quarterly Assessment was due on 07/18/25 and it was the MDS nurse's responsibility to complete it. She stated not completing the resident's assessment could impact her overall care. In an interview on 08/19/25 at 1:07 PM, the DON was advised rResident #54 did not have an MDS Quarterly assessment completed since 04/18/25 and she stated it should have been completed by the MDS nurse. She stated the MDS nurse was new and was trying to get caught up. She stated not completing the assessment could result in missed change of conditions and care for the resident. Record review of the Facility's policy on Minimum Data Set, revise 09/28/23, reflected A licensed nurse will conduct or coordinate each assessment with the interdisciplinary team. A quarterly review assessment is completed using the standardized Quarterly review assessment tool specified by the State and approved by CMS no less than once every 3 months between comprehensive assessments.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs were identified in the comprehensive assessment for a resident for 2 of 8 residents (Residents #1 and #50) reviewed for Care Plans. The facility failed to ensure Resident #1's usage of a BiPAP device was care planned. The facility failed to ensure Resident #50 was care planned for requiring feeding assistance. These failures could place the residents at risk of not receiving the necessary care and services required. Findings include: 1. Record review of Resident #1's Face Sheet, dated 08/18/25, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Relevant diagnoses included atrial fibrillation (irregular heartbeat), and heart failure. Record review of Resident #1's Quarterly MDS assessment, dated 07/25/25, reflected she had a severe cognitive impairment with a BIMS score of 3. Active diagnosis included heart failure. Record review of Resident #1's Physician orders, dated 08/18/25, reflected Noninvasive ventilation via BiPAP ST. Parameters are IPAP 8.2 CM H2O, EPAP 2.2 CM H2O on RA Via Medium Size face mask to be administered QHS & PRN during naps. Record review of Resident #1's Quarterly Care Plan, dated 07/23/25, did not reflect a care plan for the resident's use of the BiPAP machine. In an interview of 08/18/25 at 12:25 PM, ADON B stated Resident #1 had physician orders for use of a BiPAP machine. She was advised the resident's care plan did not reflect a plan of care for the BiPAP machine. She stated the resident should have been care planned for the use of the equipment to ensure the resident was receiving the care. She stated it was both the ADON and MDS nurse's responsibility to ensure the resident's use of the BiPAP machine was care planned. In an interview on 08/19/25 at 12:53 PM, the DON was advised Resident #1 did not have a care plan for the BiPAP machine, and she stated the resident should have been care planned. She stated the importance of the BiPAP machine being care planned was to avoid the resident having reparatory issues. In an interview on 08/18/25 at 1:00 PM, MDS Nurse G was advised Resident #1 did not have a care plan for the use of the BiPAP machine. She stated the resident should have had it on her care plan, because it ensured the resident received the care for use of the BiPAP machine. She stated it was MDS and the ADON's responsibility to ensure that it was care planned. Record review of Resident #50's Face Sheet, dated 08/18/25, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #50 had diagnoses of severe protein-calorie malnutrition, and dysphagia (difficulty swallowing). Record review of Resident #50's Quarterly MDS Assessment, dated 07/15/25, reflected Resident #50 had severe cognitive impairment with a BIMS score of 3. The Quarterly MDS Assessment reflected the resident required total assistance for feeding. Record review #50's physician order, dated 08/18/25, reflected Eating with assist of X 1 Person Record review #50's Comprehensive Care Plan, dated 08/14/25, did not reflect a care plan for feeding assistance. In an interview on 08/18/25 at 10:02 AM, MDS Nurse C was asked about Resident #50's care plan for feeding assistance. She stated the resident did have physician orders for a mechanical diet and required feeding assistance. She stated both concerns should have been care planned. She stated all care pertaining to the resident should be care planned to ensure the resident received proper care. She stated the MDS Nurse and the ADON were responsible for updating the resident's care plan. In an interview on 08/19/25 at 12:53 PM, ADON B advised Resident #50 required feeding assistance, and it should have been care planned. She stated MDS and the nursing staff was responsible for updating the care plans. She stated if the assist feeding was not care planned the resident could be at risk of weight loss. In an interview on 08/19/25 at 12:49 PM, the DON was advised of Resident #50 not being care planned for assist feeding and resident #1 should have been care planned for the use of a BiPAP machine. She stated the MDS nurse (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was new and was trying to get caught up with updating resident care plans. She stated not having the BiPAP machine and assist feeding care planned could result in the residents not receiving the proper care. Record review of facility's policy, CARE PLAN PROCESS, PERSON-CENTERED CARE (05/05/23) reflected 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 meet professional standards of quality care. Person-centered care means the facility focuses on the resident as the center of control and supports each resident in making his or her own choices. Person-centered care includes trying to understand what each resident is communicating, verbally and nonverbally, identifying what is important to each resident with regard to daily routines and preferred activities, and understanding the resident's life before coming to reside in the nursing home.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide appropriate treatment and services to prevent complications of enteral feeding for one (Resident #70) of two residents reviewed for feeding tube (a way of providing nutrition directly to the stomach). The facility failed to ensure RN C would not use too much water to flush Resident #70's medication via g-tube (gastrostomy tube: a tube inserted through the abdomen that delivers nutrition directly to the stomach). This failure could place residents with g-tubes at risk for aspiration, discomfort, and overhydration. Findings included: Record review of Resident #70's Face Sheet, dated 08/18/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with dysphagia (difficulty in swallowing). Record review of Resident #70's Comprehensive MDS Assessment, dated 07/28/2025, reflected the resident was cognitively intact with a BIMS score of 13. The Comprehensive MDS Assessment indicated the resident had a feeding tube. Record review of Resident #70's Comprehensive Care Plan, dated 07/28/2025, reflected the resident was at risk for aspiration due to presence of feeding tube and one of the approaches was to observe for signs of aspiration (fluid or solid substance entered the airway). Record review of Resident #70's Physician Order, dated 07/31/2025, reflected Enteral Feeding (delivery of food through feeding tube): Flush tube with 60 cc warm water before and after medication administration; 10 - 15 cc flush between each med. Record review of Resident #70's Physician Order, dated 07/29/2025, reflected RISK: choking, swallowing, aspiration, weight loss/gain, dehydration. Record review of Resident #70's Physician Order, dated 07/25/2025, reflected Venlafaxine (medication used for depression) 150 mg ER via gastric tube two times a day. Observation and interview on 08/13/2025 at 7:28 AM revealed RN C was about to administer Resident #70's medication via g-tube. She said she would be administering four medications for the resident. RN C sanitized her hands and put on a pair of gloves. She started placing the medications in a cup separately, crushed three of the medications, and returned the crushed medications to their respective small plastic cups. One of the medications, Venlafaxine 150 mg, was a capsule and RN C opened the capsule and placed its content in a cup. It was observed that the content of the capsule was in granules form. After placing the medications in the cups, she prepared two big cups of water. She said she would use the water to flush the g-tube and to dissolve the medications. She placed what she prepared on a tray, went inside the room, and placed the tray on top of the resident's overbed table. She also brought with her a plastic spoon and placed it on the tray. She raised the resident's bed and disconnected the g-tube from the formula. She then pulled the plunger (movable part of the syringe that pulls or pushes liquid into the syringe) of a 60 ml piston syringe and connected it to the g-tube. She pushed the plunger to check the placement of the g-tube and then pulled the plunger to check for the residual. She disconnected the syringe and pulled the plunger all the way and connected the syringe without the plunger. She then put approximately 10 ml of water on each medication and stirred them using the plastic spoon. She flushed the g-tube with 60 ml of water, poured the first medication, and flushed the g-tube with 15 ml of water. She did the same procedure up to the third medication. She then poured the last medication. It was observed the granules were still intact even after she put some water on it and even after stirring it. She poured the granules with water in the syringe. The granules got stuck where the syringe was connected to the g-tube. She said she was having a hard time with the last medication because the granules did not dissolve easily and would not go through. She poured 30 ml of water in the syringe and rocked the syringe back and forth. When there was no more water in the syringe, she said she would pour another 30 ml because the granules were still in the syringe. She rocked the syringe back and forth again. She then poured some more water, approximately 15 ml, seven times until all the granules passed through the syringe. She then said since she already used a lot of water on the last (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication, she would only flush the g-tube with 30 ml. After flushing the last 30 ml, she connected the g-tube to the formula, threw away the cups that she used, and washed her hands. In an interview on 08/18/2025 at 8:57 AM, RN C stated she had a hard time with Resident #70's last medication because the granules would not pass through the syringe. She said the granules did not easily dissolve and got stuck where the syringe was connected to the g-tube. She said because the granules got stuck, she had a hard time flushing because of the stuck granules. She said she used a lot of water just to flush the last medication. She said she knew she was only supposed to flush 60 ml before and 60 ml after medications and 15 ml between medications but ended up pouring too much water because she had to make sure the granules would go through. She said too much water could cause fluid overload and bloating of the stomach. In an interview on 08/19/2025 at 7:02 AM, ADON B stated it was important to flush the g-tube to prevent clogging the tubing and to make sure that the medications administered went through. She said there were certain amounts of water ordered for flushing before and after medication administration and in between medications. She said more than or less than the ordered amount of water could have an effect on the resident. She said less fluid could cause dehydration and more water could cause fluid overload, vomiting, and aspiration. She said flushing a medication with more than 100 ml of water was not right. She said she would talk with RN C to ask what happened and what could be done to prevent the issue from happening again. In an interview on 08/19/2025 at 7:16 AM, the DON stated there was a specific amount of water incorporated during medication administration via g-tube to avoid dehydration, overhydration, and aspiration. Too much water given for one flushing could lead to aspiration. She said the expectation was that the staff would use water for flushing as required. She said she would do an in-service about g-tube focusing on the amount of water needed during medication administration. In an interview on 08/19/2025 at 7:32 AM, the Administrator stated the expectation was for the staff to follow the right procedure in administering medications via g-tube. She said she was not a clinician and would let the DON and the ADONs take the lead in educating the staff about the issue. Record review of the facility's policy GASTROSTOMY TUBES Nursing Policies and Procedures, dated May 5, 2023, revealed POLICY: Gastrostomy tubes may be used for residents who require enteral feedings to maintain nutrition . electrolyte balance . resident will be offered sufficient fluids to maintain proper hydration . prevent complications of enteral feeding, like aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.		