

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024
NAME OF PROVIDER OR SUPPLIER Cedar Hollow Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5011 North US Hwy 75 Sherman, TX 75090	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34918</p> <p>Based on observation, interview and record review, the facility failed to provide the necessary services to maintain good personal hygiene to a resident who is unable to carry out activities of daily living for two of three residents (Resident #2 and Resident #3) reviewed for ADL care.</p> <ol style="list-style-type: none"> The facility failed to provide Resident #2, who required extensive assistance, with timely incontinence care on 12/10/24 from 9:00 a.m. to 01:30 p.m. The facility failed to provide Resident #3, who required extensive assistance, with timely incontinence care on 12/10/24 from 9:35 a.m. to 01:45 p.m. <p>This failure could place residents at risk of skin breakdown, urinary tract infections and loss of dignity.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Record Review of Resident #2's quarterly MDS assessment, dated 10/26/24 reflected an [AGE] year-old female admitted to the facility on [DATE]. Resident #2 was assessed by the staff to be severely cognitively impaired and unable to participate in the interview for mental status. She had limited range of motion of both lower extremities, was dependent for toileting hygiene and required substantial to maximum assistance with toilet transfers. She was always incontinent of bladder and bowel. She had received hospice services. Diagnoses included Alzheimer disease. <p>Review of Resident #2's care plan initiated on 01/17/24 reflected, I have incontinence related to Alzheimer's and immobility .Goal- I will remain free from skin breakdown due to incontinence and brief use through 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.</p> <p>In an observation on 12/10/24 at 10:15 a.m. Resident #2 was observed in the common area next the nurse's station.</p> <p>In an observation on 12/10/24 at 11:45 a.m. Resident #2 was taken from the common area to the dining room without being checked for incontinence.</p> <p>(continued on next page)</p>

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024
NAME OF PROVIDER OR SUPPLIER Cedar Hollow Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5011 North US Hwy 75 Sherman, TX 75090	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview with CNA B on 12/10/24 at 12:55 p.m. she stated Resident #2 was gotten up by the night shift and was up in her wheelchair when she comes on duty at 06:00 a.m. She stated hospice comes and takes care of her. She stated she thought she checked her at 9:00 a.m. but she did not change her. She stated she did not check her before she was taken to the dining room for lunch. She stated they were supposed to check all residents who were incontinent of urine every 2 hours but stated breakfast trays come out around 8:00a.m. and then lunch trays around 12:30 p.m. it was hard to get to everyone.</p> <p>In an observation on 12/10/24 at 01:00 p.m. Resident #2 was pushed back to the common area by her family member who had assisted her with her lunch.</p> <p>In an interview with CNA F on 12/10/24 at 01:10 p.m. she stated Resident #2's hospice aide always came after lunch.</p> <p>In an interview with ADON A on 12/10/24 at 01:15 p.m. she stated staff were check and change residents who were incontinent every 2 hours, regardless of if the resident received hospice care. She stated residents should be checked before taking them to the dining room for their meals.</p> <p>In an observation on 12/10/24 at 1:35 p.m. Hospice CNA D pushed Resident #2 from the common living area to her room. Hospice CNA D put on gloves and pushed resident's wheelchair into the bathroom and face the wheelchair toward the grab bars on the wall. She assisted the resident to place her hands on the grab bar and with prompting and pulling up on the back of the resident's pants, assisted her to a standing position. Resident's pants were soaked through with urine. Hospice CNA D pulled down the resident's pants and removed the residents wet brief. The resident's knees started to buckle, and Hospice CNA wiped the urine off the wheelchair cushion and placed a towel over the cushion and guided the resident back into the chair. Hospice CNA continued to provide peri-care to the resident and had her stand again to clean her from front to back and put on clean brief and pants.</p> <p>In an interview with Hospice CNA D on 12/10/24 at 01:40 p.m., she stated she usually came and provided care for Resident #2 after lunch. She stated she usually found her soaked in urine. She stated she had not told anyone about finding her soaked, she stated she just took care of her when she got to the facility. She stated going forward, she would let the staff know when she found her soaked.</p> <p>2. Record Review of Resident #3's quarterly MDS assessment, dated 10/02/24 reflected an [AGE] year-old female admitted to the facility on [DATE]. Resident #3 was assessed by the staff to be severely cognitively impaired and unable to participate in the interview for mental status. She had limited range of motion of both lower extremities, was dependent for toileting hygiene and was dependent on transfers from chair to bed. She was always incontinent of bladder and bowel. She had received hospice services. Diagnoses included Alzheimer disease and end stage renal disease.</p> <p>Review of Resident #3's care plan revised on 08/05/24 reflected, I have (mixed)bladder incontinence .Goal- I will remain free from skin breakdown due to incontinence and brief use through the review date . Interventions .Incontinent: check me every 2 hours and as required for incontinence change clothing PRN after incontinence episodes .</p> <p>In an observation on 12/10/24 at 10:15 a.m. Resident #3 was observed in the common area next the nurse's station.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024
NAME OF PROVIDER OR SUPPLIER Cedar Hollow Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5011 North US Hwy 75 Sherman, TX 75090	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an observation on 12/10/24 at 11:45 a.m. Resident #3 was taken from the common area to the dining room without being checked for incontinence.</p> <p>In an observation on 12/10/24 at 12:55 p.m. Resident #3 was observed back in the common area by the nurse's station.</p> <p>In an interview with CNA B on 12/10/24 at 01:40 p.m. she stated they had gotten Resident #3 up around 07:00 a.m. and had provided care to her at that time. She stated she thought hospice came mid-morning. She stated she did not check Resident #3 for incontinence before she was taken to the dining room for lunch. She stated she was waiting on her partner, and they were about to lay her down and check her.</p> <p>In an observation on 12/10/24 at 01:45 p.m. CNA B and Agency CNA C were observed pushing Resident #3 to her room. CNA B retrieved the mechanical lift from the hallway. Both staff washed their hands and put on gloves. Resident was transferred from the wheelchair to the bed and was rolled from side to side to remove the lift sling. CNA B unfastened the resident's brief and cleaned from front to back and then rolled the resident onto her side with assistance from Agency CNA C. Resident had a moderate size bowel movement. Skin was slightly red, but no breakdown noted. CNA B finished with incontinence care, placed a clean brief on the resident and repositioned her in the bed.</p> <p>In a telephone interview on 12/10/24 at 02:16 p.m. with Hospice Aide E, she stated she and her co-worker arrived at the facility today (12/10/24) around 09:30 a.m. She stated they did not change Resident #3, stating the stripes on the brief did not indicate she was wet. She stated they did not smell anything that would indicate she had a bowel movement, but stated they did not get her out of the chair and check her bottom or peri-area. She stated they washed her face and wiped down her body while she was in the chair. She stated today was not her shower day.</p> <p>In an interview with the DON on 12/12/24 at 10:00 a.m. she stated incontinent residents were to be checked and changed every two hours. She stated failing to do this could cause skin breakdown and puts them at risk of urinary tract infections. She stated it should not matter if the resident was on hospice, it was the responsibility of their staff to ensure residents were checked and changed. She stated she expected the nurses to monitor the residents who were taken to the common area to make sure they were not left there for long periods of time without getting repositioned and checked for incontinence. She stated all resident needed to be checked before going to the dining room.</p> <p>Review of the facility's policy titled, Perineal Care, dated December 2023, reflected, The purpose of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irradiation, and to observe the resident's skin condition .</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024
NAME OF PROVIDER OR SUPPLIER Cedar Hollow Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5011 North US Hwy 75 Sherman, TX 75090	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34918</p> <p>Based on observation, interview, and record review the facility failed to ensure residents receive adequate supervision and assistance devices to prevent accidents for two of eight residents (Resident #1 and Resident # 2) reviewed for quality of care</p> <ol style="list-style-type: none"> The Facility failed to ensure CNA I used a gait belt when transferring Resident #1 from her wheelchair to the toilet on 12/10/24. The Facility failed to ensure Hospice Aide D used a gait belt when standing Resident #2 up in the bathroom to provide incontinence care on 12/10/24. <p>These failures could affect the residents by placing the residents at risk for discomfort, pain, falls, injuries, and skin tears.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Record Review of Resident #1's quarterly MDS assessment, dated 10/24/24 reflected an [AGE] year-old female admitted to the facility on [DATE]. Resident #1 was moderately cognitively impaired with a BIMs of 12. She had limited range of motion of both lower extremities, required substantial to maximum assistance with toileting hygiene and toilet transfers and was always incontinent of bladder and occasionally incontinent of bowel. Diagnoses included heart failure, cerebral vascular accident (stroke) and hemiplegia (weakness or paralysis of one side of the body). <p>Review of Resident #1's care plan revised on 12/10/24 reflected, I am at risk for falls related to mobility issues, cognitive impairment .Goal- I will not sustain serious injury through the review date .Interventions . Anticipate and meet my needs .I need a safe environment .Focus .I have an ADL self-Care performance deficit related to CVA with left hemiparesis and balance deficit .Intervention .I require extensive assistance with one staff participation to use toilet .</p> <p>In an observation and interview on 12/10/24 at 10:30 a.m. Resident #1 was observed in her wheelchair sitting in the doorway of her room. She stated she was waiting for someone to come and assist her to the toilet. She stated she hated to be a bother, but stated she had to have some help.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024
NAME OF PROVIDER OR SUPPLIER Cedar Hollow Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5011 North US Hwy 75 Sherman, TX 75090	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An observation on 12/10/24 at 10:35 a.m. revealed CNA I entered Resident #1 room, put on gloves, and pushed the resident's wheelchair into the bathroom. CNAI faced the resident toward the wall and instructed to reach for the grab bars and then assisted the resident into a standing position by pulling up on the back of her pants, with no gait belt in use. CNA I then moved the wheelchair away and pulled down the resident's pants, which were wet and removed her brief revealing she was saturated with urine and had a smear of bowel movement on her right upper buttocks. Resident stated she needed to sit down. CNA I guided her back toward the toilet and sat her on the toilet. Resident #1 was able to void. CNA I then removed her gloves, washed her hands, and gathered clean brief and clean pants for the resident. CNA I put on gloves and instructed the resident to hold to the grab bar and assisted her to stand and she provided peri care from front to back. Resident #1's skin was intact. CNA I then had the resident sit back down on the toilet while she placed brief and pants over her feet. CNA I then had the resident stand while she pulled up the brief and pants and then assisted her back to the wheelchair.</p> <p>In an interview with CNA I on 12/10/24 at 10:45 a.m. she stated she was not sure of Resident #1 was a fall risk, but stated they were supposed to use a gait belt anytime they assisted with a transfer. She stated a gait belt was used to help steady a resident and help prevent a fall.</p> <p>2. Record Review of Resident #2's quarterly MDS assessment, dated 10/26/24 reflected an [AGE] year-old female admitted to the facility on [DATE]. Resident #2 was assessed by the staff to be severely cognitively impaired and unable to participate in the interview for mental status. She had limited range of motion of both lower extremities, was dependent for toileting hygiene and required substantial to maximum assistance with toilet transfers. She was always incontinent of bladder and bowel. She had received hospice services. Diagnoses included Alzheimer disease.</p> <p>Review of Resident #2's care plan initiated on 01/30/24 reflected, I am at risk for falls related to Gait balance problems .Goal- I will not sustain serious injury through the review date .Interventions .Keep me in view of staff when up in wheelchair .Toilet use .I require extensive assistance of 1 staff participation to use toilet .</p> <p>In an observation on 12/10/24 at 1:35 p.m. Hospice CNA D pushed Resident #2 from the common living area to her room. Hospice CNA D put on gloves and pushed resident's wheelchair into the bathroom and face the wheelchair toward the grab bars on the wall. She assisted the resident to place her hands on the grab bar and with prompting and pulling up on the back of the resident's pants, assisted her to a standing position. Resident's pants were soaked through with urine. Hospice CNA D pulled down the resident's pants and removed the residents wet brief. The resident's knees started to buckle, and Hospice CNA wiped the urine off the wheelchair cushion and placed a towel over the cushion and guided the resident back into the chair. Hospice CNA continued to provide peri-care to the resident and had her stand again to clean her from front to back and put on clean brief and pants.</p> <p>In an interview with Hospice CNA D on 12/10/24 at 01:40 p.m., she stated Resident #2 could stand for short periods of time but could lose her balance. She stated she was supposed to use a gait belt and realized after she had stood her up, she had forgotten to put it on her. She stated a gait belt helped stabilize the resident if they started to fall.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024
NAME OF PROVIDER OR SUPPLIER Cedar Hollow Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5011 North US Hwy 75 Sherman, TX 75090	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with ADON A on 12/10/24 at 03:30 a.m. she stated staff were to use gait belt for transfers. Stated she stated she had only been in this position for a few months, and she was not sure when the last gait belt training had been done, but stated she would get CNA I was in serviced today.</p> <p>In an interview with the DON on 12/10/24 at 04:26 p.m. she stated the provided gait belt/transfer skills check on CNA I today (12/10/24) and had reached out to the Hospice agency who stated CNA D had already informed them of what she had done. She stated the Hospice agency would be in servicing their staff. She stated she was unable to locate any previous training for gait belt training for CNA I. She said it was the expectation for staff to use a gait belt when providing transfers to residents to prevent the risk of injury to the resident and the staff. She stated they had placed gait belts in the resident's room who required transfer assistance. She stated they had begun in services on all the staff to ensure they were all trained and knew the expectation for the use of gait belts.</p> <p>In an interview with PT J on 12/11/24 at 09:25 a.m. he stated he had done some employee training with gait belts, but it was not something they did on a routine basis. He stated his expectation for safe transfers was any resident who needed contact assistance with a transfer would need a gait belt to assist with fall recovery and or prevent falls.</p> <p>Record review of CNA I's skills check list titled Pivot transfers One-person and Two-person, dated 12/10/24, reflected she had met acceptable performance in the task.</p> <p>Record review of the facility's policy, Safe lifting and Movement of Residents dated December 2023, reflected, In order to protect the safety and well-being of staff and residents, and to promote quality of care, this facility uses appropriate techniques and devices to lift and move residents .Staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts, lateral boards) and mechanical lifting devices .</p>		