STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676488	A. Building B. Wing	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Hollow Rehabilitation Center	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)
F 0656 Level of Harm - Immediate jeopardy to resident health or safety 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. (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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, 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 that were identified in the comprehensive assessment for one of four residents (Resident #1) reviewed for care plans. The facility failed to ensure Resident #1's care plan was implemented when CNA B attempted to transfer the resident himself, instead of using a mechanical lift, which resulted in a fall. Resident #1 was hospitalized and required surgery for a fracture of the left femur.The non-compliance was identified as PNC. The noncompliance began on 11/30/2025 and ended 12/01/2025. The facility had corrected the non-compliance before the survey began.This deficient practice could place residents at risk of harm and serious injury due to not receiving the appropriate care and services.Findings include:Record review of Resident #1's Face Sheet, dated 12/30/2025, reflected a [AGE] year-old female who initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1 had diagnoses which included dementia (decline in cognitive function that interferes with daily life), age-related osteoporosis (bone density decreases as people age, leading to fragile bones), and initial encounter for a left femur (long bone in upper leg) closed fracture (broken bone with intact skin). Record review of Resident #1's Quarterly MDS Assessment, dated 12/19/2025, reflected the resident was cognitively intact with a BIMS score of 13. Section GG (Functional Abilities) indicated Resident #1 was dependent on staff for self-care and mobility needs.Record review of Resident #1's Comprehensive Care Plan, dated 09/09/2025, reflected ADL Self Care Performance Deficit r/t muscle weakness, Dementia, pain. One intervention was TRANSFER: I require Hoyer lift for transfers. Record review of Resident #1's Comprehensive Care Plan, dated 09/09/2025, reflected Alteration in musculoskeletal status r/t fracture of the left femur. Date Initiated:12/09/2025. One intervention was to Follow MD orders for weight bearing status.I currently have orders for WBAT to LLE with immobilizer in place. Initiated 12/09/2025.Record review of CNA B's statement in the incident report, dated 11/30/2025, reflected Resident #1 confirmed that she was ready to get up and was assisted to the side of the bed. Resident stood up and almost immediately her legs gave up and I assisted her to the floor. I immediately got the nurse for the nursing assessment. Resident was placed back in bed for nurse to complete her assessment. Once she got in bed, resident began complaining of pain to left leg.Record review of LVN B's statement in the incident report, dated 11/30/2025, reflected While resident was being changed and being put in wc she was lowered to the floor by CNA. Resident was put back into her bed after being assessed. No complaints of pain initially. After she was back in bed she began complaining of left leg pain. Unable to determine if injury had occurred. 911 was called d/t the extent of the pain when touching and moving left leg. The incident report indicated the resident was sent to the hospital for further evaluation. Record review of the facility's self-report of the incident, dated 11/30/2025, reflected CNA B transferred Resident #1 without using a mechanical lift. The report reflected Resident #1's legs gave out and CNA B lowered her to the floor. Resident #1 was transferred to the hospital for evaluation. Record review of Resident #1's Hospital Report, dated 11/30/2025, reflected a left distal femur fracture which required surgery.Record review of Resident #1's Comprehensive Care Plan, dated 12/01/2025, reflected the care plan was updated to include the use of a Hoyer lift with 2 staff members. An observation on 12/30/2025 at 1:40 PM revealed CNA D and CMA E appropriately completed a Hoyer lift transfer.In an observation and interview on 12/30/2025 at 10:09 AM, Resident #1 was lying in bed awake. When asked about a recent fall, Resident #1 stated a guy was trying to move her from her bed to her wheelchair when she fell and broke her leg. She was not sure if it was a CNA. She stated it did not happen here but she did not remember where the incident occurred. Resident #1 denied pain and stated she could tell someone if she needed pain medication. During an interview on 12/30/25 at 10:29 AM, RN A stated she cared for Resident #1 but was not working when the incident occurred. She stated LVN C and CNA B were working at the time, but it was their day off. RN A stated Resident #1 had become weaker and could not bear weight on her legs. She stated it was a safety issue. She stated staff transferred Resident #1 with a Hoyer lift to/from the bed and wheelchair. She stated prior to the fall, Resident #1 would be up for about 30 minutes and wanted to go back to bed. Attempted interview on 12/30/2025 at 11:07 AM was unsuccessful. A voicemail was left for CNA B requesting a return call. Attempted interview on 12/20/2025 at 11:17 AM was unsuccessful. A voicemail was left for LVN C requesting a return call. During an interview on 12/30/25 at

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for one of four residents (Resident #1) reviewed for accidents and hazards.The facility failed to ensure Resident #1 was properly transferred from her bed to her wheelchair. CNA B attempted to transfer the resident by himself, instead of using a mechanical lift, which resulted in a fall. Resident #1 was hospitalized and required surgery for a fracture of the left femur.The non-compliance was identified as PNC. The noncompliance began on 11/30/2025 and ended 12/01/2025. The facility had corrected the non-compliance before the survey began.This failure could place the residents at risk of accident, injury or serious harm. Findings include:Record review of Resident #1's Face Sheet, dated 12/30/2025, reflected a [AGE] year-old female who initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1 had diagnoses which included dementia (decline in cognitive function that interferes with daily life), age-related osteoporosis (bone density decreases as people age, leading to fragile bones), and initial encounter for a left femur (long bone in upper leg) closed fracture (broken bone with intact skin).Record review of Resident #1's Quarterly MDS Assessment, dated 12/19/2025, reflected the resident was cognitively intact with a BIMS score of 13. Section I (Active Diagnoses) reflected a fracture of the left femur with routine healing. Record review of Resident #1's Comprehensive Care Plan, dated 09/09/2025, reflected ADL Self Care Performance Deficit r/t muscle weakness, Dementia, pain. One intervention was TRANSFER: I require Hoyer lift for transfers. Record review of Resident #1's Comprehensive Care Plan, dated 09/09/2025, reflected Alteration in musculoskeletal status r/t fracture of the left femur. Date Initiated:12/09/2025. One intervention was to Follow MD orders for weight bearing status.I currently have orders for WBAT to LLE with immobilizer in place. Initiated 12/09/2025.Record review of CNA B's statement in the incident report, dated 11/30/2025, reflected Resident #1 confirmed that she was ready to get up and was assisted to the side of the bed. Resident stood up and almost immediately her legs gave up and I assisted her to the floor. I immediately got the nurse for the nursing assessment. Resident was placed back in bed for nurse to complete her assessment. Once she got in bed, resident began complaining of pain to left leg.Record review of LVN B's statement in the incident report, dated 11/30/2025, reflected While resident was being changed and being put in wc she was lowered to the floor by CNA. Resident was put back into her bed after being assessed. No complaints of pain initially. After she was back in bed she began complaining of left leg pain. Unable to determine if injury had occurred. 911 was called d/t the extent of the pain when touching and moving left leg. The incident report indicated the resident was sent to the hospital for further evaluation. Record review of the facility's self-report of the incident, dated 11/30/2025, reflected CNA B transferred Resident #1 without using a mechanical lift. The report reflected Resident #1's legs gave out, and CNA B lowered her to the floor. Resident #1 was transferred to the hospital for evaluation. Record review of Resident #1's Hospital Report, dated 11/30/2025, reflected a left distal femur fracture which required surgery.Record review of Resident #1's Comprehensive Care Plan, dated 12/01/2025, reflected the care plan was updated to include the use of a Hoyer lift with 2 staff members. An observation on 12/30/2025 at 1:40 PM revealed CNA D and CMA E appropriately completed a Hoyer lift transfer.In an observation and interview on 12/30/2025 at 10:09 AM, Resident #1 was lying in bed awake. When asked about a recent fall, Resident #1 stated a guy was trying to move her from her bed to her wheelchair when she fell and broke her leg. She was not sure if it was a CNA. She stated it did not happen here but she did not remember where the incident occurred. Resident #1 denied pain and stated she could tell someone if she needed pain medication. During an interview on 12/30/25 at 10:29 AM, RN A stated she cared for Resident #1 but was not working when the incident occurred. She stated LVN C and CNA B were working at the time, but it was their day off. RN A stated Resident #1 had become weaker and could not bear weight on her legs. She stated it was a safety issue. She stated staff transferred Resident #1 with a Hoyer lift to/from the bed and wheelchair. She stated prior to the fall, Resident #1 would be up for about 30 minutes and wanted to go back to bed. Attempted interview on 12/30/2025 at 11:07 AM was unsuccessful. A voicemail was left for CNA B requesting a return call. Attempted interview on 12/20/2025 at 11:17 AM was unsuccessful. A voicemail was left for LVN C requesting a return call. During an interview on 12/30/25 at 11:28 AM, the DON stated CNA B should have used a Hoyer lift to transfer Resident #1 instead of attempting to transfer her by himself from the bed to the wheelchair. She stated Resident #1 was sent to the hospital and had surgery for a fracture. She

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that a resident, who needed respiratory care, was provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one of four (Resident #1) residents reviewed for respiratory care.The facility failed to ensure Resident #1's nebulizer mask (device used to deliver medication in a mist form through the nose and mouth) was properly stored when not in use on 12/30/2025.This failure could place residents at risk for respiratory infection and not having their respiratory needs met.Findings include: Record review of Resident #1's Face Sheet, dated 12/30/2025, reflected a [AGE] year-old female who initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1 had diagnoses which included acute and chronic respiratory failure with hypoxia (not enough oxygen in the blood) and shortness of breath. Record review of Resident #1's Quarterly MDS Assessment, dated 12/19/2025, reflected the resident was cognitively intact with a BIMS score of 13. Section I (Active Diagnoses) reflected respiratory failure. Section O (Special Treatments, Procedures, and Programs) reflected Resident #1 received oxygen therapy. Record review of Resident #1's Comprehensive Care Plan, dated 12/30/2025, reflected Resident #1 had oxygen therapy as needed related to respiratory failure. One intervention was to give medication as ordered and monitor for signs of respiratory distress.Record review of Resident #1's Physician Order, dated 12/05/2025, reflected Budesonide Inhalation Suspension 0.5 MG/2ML Budesonide (Inhalation) 1 vial inhale orally two times a day for acute and chronic respiratory failure with hypoxia.During an observation on 12/30/2025 at 10:09 AM, revealed Resident #1 was lying in bed. Resident #1 was receiving oxygen therapy via nasal cannula (device used to deliver oxygen into the nostrils). An empty plastic bag hung from the nightstand drawer handle. Resident #1 gave permission for the drawer to be opened. A nebulizer machine with connected tubing and a face mask was in the drawer with other personal items. The nebulizer mask was not in a bag. Resident #1 stated she did not know if the nebulizer mask was supposed to be in a bag. During an interview on 12/30/25 at 10:29 AM, RN A stated the nebulizer mask should have been stored in a bag when not in use. She stated as the resident's nurse, she was responsible for ensuring it was stored in a bag when the resident was not receiving a breathing treatment. She stated the risk to the resident was respiratory infection.During an interview on 12/30/25 at 11:28 AM, the DON stated the nebulizer mask should have been stored in a bag when not in use. She stated that any staff member could notice if it was not bagged and notify the nurse. She stated ultimately the nurse was responsible. She stated it was important to prevent infection. Record review of the facility's policy Departmental (Respiratory Therapy) - Prevention of Infection, reviewed December 2024, reflected Infection Control Considerations Related to Nebulizer/Continuous Aerosol. Store the circuit in plastic bag, marked with date and resident's name, between uses.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, interview, and record review, the facility failed to ensure, in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls, and permitted only authorized personnel to have access to the keys for one of five (Resident #1) residents reviewed for medication storage.The facility failed to ensure over the counter medication was not on Resident #1's bedside table on 12/30/2025. This failure could place the residents at risk of accidental overdose or misuse of medication.Findings include: Record review of Resident #1's Face Sheet, dated 12/30/2025, reflected a [AGE] year-old female who initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1 had diagnoses which included dementia (decline in cognitive function that interferes with daily life), age-related osteoporosis (disease that weakens bones), and initial encounter for a left femur (long bone in upper leg) closed fracture (broken bone with intact skin). Record review of Resident #1's Quarterly MDS Assessment, dated 12/19/2025, reflected the resident was cognitively intact with a BIMS score of 13. Section GG indicated Resident #1 was dependent on staff for self-care and mobility needs. Record review of Resident #1's Comprehensive Care Plan, dated 12/01/2025, did not reflect the resident self-administered her medication.During an observation and interview on 12/30/2025 at 10:09 AM, revealed Resident #1 was lying in bed awake. The bedside table was placed over the right side of her bed. A plastic container on the bedside table held a tube of Voltaren cream (treats arthritis pain), a box of Pepto Bismol chewable tablets (used to treat nausea and heartburn), saline nasal spray (moistens and clears the nasal passage), Icy Hot pain relief cream (used for muscle and joint pain), and Mentholatum ointment (used to relieve minor aches, pain, and congestion). The plastic container also held other personal items. Resident #1 stated the medicine was there in case she needed it. During an interview on 12/30/25 at 10:29 AM, RN A stated Resident #1 had several family members who came to see her and at times went to the store and brought items the resident requested. She stated medication should not be left in Resident #1's room unless she was assessed and checked off to self-administer it. RN A removed the over-the-counter medications. Resident #1 asked what she was doing with the medication and RN A replied to ensure everyone's safety, the medications could not be left in her room. During an interview on 12/30/2025 at 11:28 AM, the DON stated Resident #1 should not have over the counter medications in her room. She stated the resident had multiple family members and facility staff had conversations with them about bringing items into her room. The DON stated the resident did not self-medicate and it was also important to ensure no one else had access to the medication. During an interview on 12/30/2025 at 3:55 PM, the Executive Director stated Resident #1 should not have medication in her room. She stated it was important for the nurse to know what medication the resident took. She stated someone else might take the medication and potentially have an adverse reaction. She stated she would send a reminder email out to all family members reminding them not to bring medication to the facility. Record review of the facility's policy Storage of Medications, reviewed December 2024, reflected The nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner. Drugs shall be stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications shall be assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents.