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	01/14/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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, to meet the needs of each resident for 1 of 5 residents (Residents #1) reviewed for pharmacy services. On 01/06/26 during bedtime, CMA A administered medications to Resident #1; thereafter, the resident vomited.The facility failed to ensure Resident #1's Tramadol HCl was administered according to physician's orders, which caused the resident to miss 1 dose on 01/06/26 for pain. The facility failed to ensure Resident #1's Atorvastatin Calcium was administered according to physician's orders, which caused the resident to miss 1 dose on 01/06/26 for hyperlipidemia (high cholesterol).The facility failed to ensure Resident #1's Farxiga was administered according to physician's orders, which caused the resident to miss 1 dose on 01/06/26 for DM.The facility failed to ensure Resident #1's Remeron was administered according to physician's orders, which caused the resident to miss 1 dose on 01/06/26 for depression. The facility failed to ensure Resident #1's Eliquis was administered according to physician's orders, which caused the resident to miss 1 dose on 01/06/26 for cerebral infraction (blood clots in the brain).The facility failed to ensure Resident #1's Protein Oral Liquid was administered according to physician's orders, which caused the resident to miss 1 dose on 01/06/26 for wound healing. These failures could place residents at risk for not receiving therapeutic dosages of their medications as ordered by the physician and a potential for decreased health status and decreased quality of life.Findings include: Record review of Resident #1's face sheet, dated 01/14/26, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included: fracture of shaft of left tibia (broken bone along the length below knee and above ankle), acute respiratory failure (lungs not providing enough oxygen), type 2 diabetes (body does not produce enough insulin), hypokalemia (lack of potassium), paroxysmal atrial fibrillation (irregular heart rhythm), cerebral infarction (brain tissue dead), orthostatic hypotension (low blood pressure), acute respiratory failure with hypoxia (inability of the respiratory system to maintain an adequate blood oxygen level to preserve normal organ function), chronic kidney disease (loss of kidney function), muscle wasting and atrophy (loss of muscle tissue), lack of coordination (difficulty with movement), hyperlipidemia (excess fats in the blood), depression (mood disorder), edema (swelling from excess fluid in body tissues), and presence of cardiac pacemaker (device to regulate the heart's rhythm). Record review of Resident #1's Admissions MDS Assessment, dated 12/09/25, reflected Resident #1 had a BIMs score of 15 out of 15, which indicated the resident was cognitively intact. The MDS Assessment under Section GG-Functional Abilities, reflected Resident #1 required partial to moderate assistance with some self-care ADLs. Further review under J-Health Conditions, reflected the resident received a scheduled pain medication regimen with pain being present occasionally. Record review of Resident #1's care plan, dated 12/02/25, reflected the resident was on (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pain medication therapy r/t injury (L.tibia and Fibula Fx). Interventions included: administering medication as ordered, asking physician to review medication if side effects persist, monitoring respirations, monitoring for altered mental status and adverse reactions, monitoring for increased risk for falls, and reviewing pain medication efficacy (desired results). Resident #1 had type 2 diabetes mellitus with diabetic neuropathy (nerve damage caused by long-term high blood sugar). Interventions included: checking all the body for breaks in skin and treating promptly as ordered, administering medication as order, monitoring and documenting side effects and effectiveness, dietary consultation for nutritional regimen and ongoing monitoring, and referring to podiatrist/foot care nurse to monitor/document foot care needs and cutting toenails. Resident #1 had dehydration and potential fluid deficit. Interventions included: administrating medications as ordered, monitoring for side effects and effectiveness, monitoring vital signs as ordered/per protocol and record, notifying MD of significant abnormalities, and notifying physician of persistent symptoms of diarrhea, nausea/vomiting unresolved past 48 hours. Resident #1 used antidepressant medication (Remeron/sertraline) r/t depression. Interventions included: giving antidepressant medications ordered by physician and documenting/monitoring side effects and effectiveness. Resident #1 was on diuretic therapy (Lasix) r/t edema. Interventions included: administrating medication as ordered, asking physician to review medication for possible dose reduction every three months, monitoring other medications for interactions/adverse consequences, observing for possible side effects q-shift, monitoring dose, and reporting pertinent lab results to MD. Record review of Resident #1's order summary, dated 01/08/26, reflected the resident was ordered the following medications: -Tramadol HCl Tablet 50 MG-give 1 tablet by mouth every 6 hours for pain. Start date: 12/09/25. - Atorvastatin Calcium Oral Tablet 20 MG-give 1 tablet by mouth at bedtime for hyperlipidemia. Start date: 12/02/25. - Farxiga Oral Tablet 5 MG (Dapagliflozin Propanediol)-give 1 tablet by mouth at bedtime for DM. Start date: 12/02/25. - Remeron Oral Tablet 30 MG (Mirtazapine)-give 1 tablet by mouth at bedtime for depression. Start date: 12/02/25. - Eliquis Oral Tablet 2.5 MG (Apixaban)-give 1 tablet by mouth every morning and at bedtime for cerebral infarction. Start date: 12/02/25. - Protein Oral Liquid-give 30 ml by mouth every morning and at bedtime for wound healing. Start date: 12/05/25. Record review of Resident #1's Medication Administration Record for 01/06/2026, reflected the following: -Tramadol HCl Tablet 50 MG was administered at 3:00 PM and 9:00 PM by CMA A. -Atorvastatin Calcium Oral Tablet 20 MG was administered at bedtime by CMA A. -Farxiga Oral Tablet 5 MG (Dapagliflozin Propanediol) was administered at bedtime by CMA A. -Remeron Oral Tablet 30 MG (Mirtazapine) was administered at bedtime by CMA A. -Eliquis Oral Tablet 2.5 MG (Apixaban) was administered at bedtime by CMA A. -Protein Oral Liquid was administered at bedtime by CMA A. Record review of Resident #1's Medication Administration Record for 01/06/2026, reflected that CMA A administered all medications with CMAs initials. The CMA A did not document the episode of vomiting. In an interview with the Administrator and DON on 01/16/26 at 10:05 AM, Surveyor requested a policy on medication administration, but a policy on medication administration schedule was received which did not address the deficient practice. In an interview on 01/16/26 at 1:49 PM, CMA A stated she had been working at the facility for over 5 years. She stated she worked on the skilled unit. She also stated she worked 6:00 AM-2:00 PM and occasionally worked the evening shifts. She stated she was a medication aide and passed as well as reordered residents' medications. CMA A stated she worked with Resident #1 on 01/06/26. CMA A stated each time she administered Resident #1's medications that day, she would regurgitate the medication. She stated she medicated Resident #1 on the evening of 01/06/26 which included Tramadol HCl, Atorvastatin, Farxiga, Remeron, Eliquis and Protein. She made three attempts to medicate Resident #1 but she was unable to state which medications. CMA A (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated on the first attempt, Resident #1 refused to take the medications. CMA A revealed on the second attempt of administering, Resident #1 spit the medications out but was unaware of exactly which medications. CMA A stated she tried to administer the third and final time while Resident #1's family member was in the room. She stated on the last attempt; Resident #1 regurgitated the medication again. She stated at the last attempt, she gave Resident #1 half the medication. When Resident #1 could not keep the medication down, CMA A threw the remaining away but unable to determine which medications. CMA A stated Resident #1's family member asked where the remaining medication was, and she told the family member she threw it away. CMA A stated she explained to the family member Resident #1 vomited the first half of the medication, so it was not like she was going to take the rest. CMA A stated protocol if a resident vomited or did not take the medications, was to report to the nurse. She stated if the medication was crushed, then they threw away the remaining of the medication that was not taken.CMA A confirmed awareness of vomiting episode; however, review of the MAR, nursing notes, and clinical record revealed no documentation of the vomiting episode, assessment of Resident #1's condition, physician notification, or monitoring for adverse events. In an interview on 01/16/26 at 2:41 PM, the DON stated she received a call on 01/19/26 from Resident #1's family complaining about medication being administered. She stated she was informed by the family that resident vomited the medication CMA A attempted to administer on 01/06/26. She stated prior to that she was not aware of Resident #1 vomiting any medications. The DON stated protocol was to document if a resident refused medications or vomited. An attempted interview on 01/06/26 at 3:00 PM with LVN B, who CMA A stated she reported to, was unsuccessful due to no response to call. In an interview on 01/14/26 at 3:15 PM, Resident #1's family member stated she visited the resident on 01/06/26 after 5:00 PM. Resident #1's family member stated when it was time for Resident #1's medication to be administered, she heard CMA A crushing it. The family member stated they were unaware of the medication being crushed. Resident #1's family member stated CMA A administered medications that were pasty and chalky in a medication cup. Resident #1's family member also stated it was thick as if CMA A did not add enough liquid. Resident #1's family revealed CMA A started with administering half the cup of medications with a spoon. The family member stated they witnessed Resident #1 regurgitating the medications. The family member stated CMA A stated, She does this all the time. She could eat food and ice cream but cannot keep her meds down. The family member stated she asked CMA A when Resident #1 would get the rest of the medication. The family member stated CMA A told them it was not much left, and she threw it away because Resident #1 was not going to keep it down anyway. The family member stated it was later reported to the DON, who stated she would investigate.