

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  03/06/2025
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 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>49427</p> <p>Based on interview and record review, the facility failed to act promptly upon the grievances of the resident group concerning issues of resident care and life in the facility and demonstrate their response and rationale for such response for 4 (11/19/2024, 12/10/2024, 01/07/2025, and 02/12/2025) of 4 Resident Council Meetings, in that:</p> <ol style="list-style-type: none"> <li>Concerns voiced during the monthly Resident Council Meetings were not addressed following meetings held on 11/19/2024, 12/10/2024, 01/07/2025, and 02/12/2025.</li> <li>The Resident Council members were not notified regarding facility action taken to address and resolve concerns voiced in prior Resident Council Meetings during the next monthly meetings held on 12/10/2024, 01/07/2025, and 02/12/2025.</li> </ol> <p>These failures placed the residents at risk for a decreased quality of life and a decreased feeling of well-being within their living environment.</p> <p>The findings included:</p> <p>Review of the Resident Council Meeting Minutes revealed the following:</p> <p>11/19/2024- 8 residents attended, and the Activity Director was present. The documented open concerns included residents left in bed and missing activities, concerns regarding staffing, nails not being cut, and call light wait times. New business was regarding long wait times for call lights, medications, and agency aides not being responsive to resident.</p> <p>12/10/2024- 6 residents attended, and the Activity Director was present. The documented open concerns were the same as the 11/19/2024 meeting. New business included: Administration- still not getting a solution about ongoing issues</p> <p>01/07/2025- 7 residents attended with open business of the same concerns from the 11/19/24 meeting. New business included concerns with internet service, aides turning the call lights off and not coming back to assist residents and customer service concerns.</p> <p>02/12/2025- 5 residents attended with open business of concerns regarding wait times for medications, staff wearing earbuds and customer service concerns. New business included missed medications on the weekends, aides talking on the phone in the resident bathrooms, and cold food.</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
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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the Grievance Log Reports from October 2024 to March 2025 for the Resident Council revealed a total of 11 grievance reports had been completed following Resident Council meetings.</p> <p>In a confidential group interview on 03/05/25 residents said the facility had not provided them a response regarding their concerns noted during resident council meetings and they wanted a written update regarding their previous concerns from each department that they had concerns in.</p> <p>In an interview on 03/06/25 at 3:56 PM with the Activity Director she said she is present for all resident council meetings, took notes for the residents, and turned in grievances into the appropriate department and gave a copy to the Administrator. She stated that the Resident Council President asked for a written action plan from each department, and she verbally informed the Administrator. She stated she was not aware if resident council received a response to their concerns. She stated that it was important for resident council to have a response to their concerns because it was their right to receive a response and know how the problem will be resolved.</p> <p>In an interview on 03/06/25 at 4:22 PM with the Administrator she said she was responsible for grievances, was aware of the Resident Council concerns, and stated she had addressed each grievance . She stated that the grievances were filed with the departments responsible; some of the concerns from resident council did not name a specific resident impacted so she noted what was done regarding the grievance on the grievance. She stated in-services with staff included call light response, CNA responsibilities including to not wear earbuds and providing incontinent care every 2 hours. She stated the facility reviewed staffing, increased staff and reduced using agency staffing. She stated that she only attended the Resident Council meetings when invited and had not spoken to the entire council about the concerns that were addressed and only spoke with the Resident Council President. She stated that communicating responses to the Resident Council was important because it was a resident rights issue, and residents have the right to be heard and treated with dignity.</p> <p>In an interview on 03/06/25 at 4:44 PM with the Resident Council President she stated Resident Council meetings were held monthly and the Activity Director wrote the meeting minutes. She stated that concerns were conveyed to the Administrator, and they had not been told of the outcome of their concerns. She stated that they could tell there were some improvements but there were still the same concerns. She stated that in the previous Resident Council meeting they asked for a written response from each department and had not heard a response yet. She stated that she understood that sometimes solutions took longer to fix but not getting a response was the biggest problem.</p> <p>Record review of the facility's grievance policy titled, Grievances/Complaints, Filing, dated revised December 2023, reflected .Residents and their representatives have the right to file grievances, either orally or in writing, to the facility staff or to the agency designated to hear grievances .</p> <p>The Administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident and/or representative .All grievances, complaints or recommendations stemming from resident or family groups concerning is-sues of resident care in the facility will be considered. Actions on such issues will be responded to verbally, including a rationale for the response . The resident, or person filing the grievance and/or complaint on behalf of the resident, will be informed of the findings of the investigation and the actions that will be taken to correct any identified problems .</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50910</p> <p>Based on observation, interview and record review, the facility failed to notify the resident representative and consult with the resident's physician, when there was an accident involving the resident which resulted in injury and had the potential for requiring physician intervention for one (Resident #15) of five residents.</p> <p>The facility failed to notify Resident #15's physician and resident representative of a bruise to her left hand and dime-sized wound on her right underarm</p> <p>This failure could place residents at risk of a delay in medical intervention and a decline in health.</p> <p>Findings included:</p> <p>Review of Resident #15's Admission MDS Assessment, dated 1/2/25, reflected she was an [AGE] year-old female with an admitted [DATE]. Resident #15 was severely cognitively impaired, and her BIMS score was unable to be determined. She had impairments to lower extremities on both sides and required extensive one-person assistance with ADLs. Resident had an indwelling catheter and had the following active diagnoses: Anemia (a condition in which the blood doesn't have enough healthy red blood cells and hemoglobin), wound infection, Non-Alzheimer's Dementia and Paraplegia (paralysis that affects both legs).</p> <p>Review of Resident #15's care plan dated 9/11/24 reflected there is a risk for pressure ulcers and the interventions included: Assess/record/monitor wound healing weekly, assess and document status of wound and healing progress, inform me/family/caregivers of any new area of skin breakdown, obtain and monitor lab/diagnostic work as ordered, report results to MD and follow up as indicated and seen by Wound Care Doctor weekly.</p> <p>Review of Resident #15's order summary printed 3/6/25 reflected, . Weekly Skin Assessment needs to be completed.</p> <p>Weekly, every day shift every Tue for Weekly Skin Documentation . with a start date of 09/12/24.</p> <p>Review of Resident #15's February and March 2025 nurse's notes did not reflect any documentation about the oval 2 inch bruise to her right hand or the dime sized wound to right underarm or notification to the family or physician of it.</p> <p>Review of incident reports for December 2024 to March 2025 did not reflect any documentation about an incident that resulted in injury to Resident #15's right hand or right under arm before 3/4/25. There were no incident reports for Resident #15.</p> <p>(continued on next page)</p>

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview of Resident #15 in her bedroom on 03/04/25 at 02:28 PM reflected resident had a purple oval bruise that was approximately two inches on her right hand by her pinky finger and a dime sized scabbed circular wound on her right underarm. Resident #15 stated she did not know what the bruise or mark was from.</p> <p>Observation of Resident #15 on 3/5/25 at 10:46am reflected that Resident #15 had a bruise to her right hand and the small circular scab to her right underarm.</p> <p>Interview of CNA V on 3/5/25 at 11:16am reflected that she provided care to Resident #15 every 2 hours. She stated that the cut on her under arm was from an incident in which her and another CNA were changing her, and her skin tore when they turned her. She was unable to provide the specific date of the incident but stated it was some time last year and the incident was documented. She stated that she believed the bruise on her hand was due to them drawing blood recently.</p> <p>Record review of incident logs for December 2024 through March 2025 did not indicate any incidents related to Resident #15.</p> <p>Interview with CNA M on 3/5/25 at 11:32am reflected that Resident #15 mark on her hand looked like a bruise but had been there a couple of weeks. She believed it may have been caused when they drew blood.</p> <p>Interview with CNA W on 3/5/25 at 12:08pm revealed that she was unaware of any other bruises or the mark on Resident #15's underarm.</p> <p>Interview and observation of Resident #15 and ADON I on 3/6/25 at 8:19am reflected that Resident #15 had a dressing on the wound on her right under arm. Treatment Nurse removed the dressing on the wound and stated she was not aware of that wound. The bandage had blood and the wound had clear pink fluid. The wound was circular and the size of a dime. She stated she would look into what happened and who put the dressing on the wound. ADON I asked Resident #15 what happened and Resident #15 was unable to say. Resident #15 had a the bruise on her right hand. ADON I stated she was unaware of the bruise on Resident #15's hand. Resident #15 was unable to state what happened or when she got the bruise.</p> <p>Interview with RN X on 3/6/25 at 8:41am revealed that she was unaware of a skin tear/wound on Resident #15's right upper arm or bruise to her right hand. She stated she had not put the dressing on it yesterday and didn't see it. She stated that the night shift must have put on the dressing, but she was not notified of it at shift change. She did not know of a bruise to her hand either. She stated now that she knew she would get the measurements and initiate the incident protocol. She would get with staff to find who found the wound and covered it. She would notify ADON, DON, doctor and responsible party of her wound.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with ADON E on 3/6/25 at 9:28am revealed that Resident #15 should have had a weekly skin assessment due to having skin integrity issues. The nurses were responsible for completing the weekly skin assessments. When a new wound was found they would call the doctor and notify the ADON I, since she was the Treatment Nurse. When a new wound was found there should be a risk management assessment for change in skin condition completed. The risk to the resident if a wound was not assessed properly was that the resident would not be able to get treatment and further deteriorate. Staff also needed to follow the care plan to ensure that skin-maintained integrity and interventions were done as ordered.</p> <p>Interview with RN Y (night nurse) on 3/6/25 at 1:19pm revealed she had worked Resident #15's hall on 3/5/25 on the night shift but was not assigned to her. She was training a new RN Z and Resident #15 was assigned to her. She was not informed of any wounds or bruises on Resident #15 during her shift and didn't know who had put the dressing on her wound. She stated she last worked with Resident #15 on Thursday or Friday of last week and did not recall seeing any bruises or new wounds. She stated that the new RN Z had not alerted her of any skin issues or new wounds on Resident #15.</p> <p>Attempted interview with RN Z on 3/6/25 at 1:34pm but there was no answer on her phone and a voicemail was left to call back. No call back received.</p> <p>Interview with DON on 3/6/25 at 12:02pm revealed that she had not been notified of Resident #15's wound or bruise on her right side. She stated that the expectation for when an injury or wound was found that the nurse notified the doctor and followed up with recommendations. The nurse would also notify her, the Administrator, and the responsible party for the resident. She stated once she was notified, she would have to do an investigation to rule out abuse or neglect and see what happened. She stated that she was unable to provide proof that the Resident's family or doctor had been notified of the bruise or abrasion since she had not been notified of it and it was the first time she heard of it.</p> <p>Interview with Executive Director on 3/6/25 at 1:46pm revealed that she had just been informed about the wound on Resident #15 in the last hour. She stated that she was not notified of the bruise or abrasion on 3/5/25 and therefore no one else had been notified. She stated that whoever had found the abrasion would have needed to do an incident report and triggering the different necessary tasks and time frames. The tasks would have included notification to doctor and responsible party and completed necessary assessments. She stated they would have needed to contact the physician to get an order to cover the wound. She stated in instances where possible injuries and abrasions are found an incident report must be completed and a list of other tasks to be completed to include notifications to relative, doctors, and assessments would have been triggered. At the time of the interview there had been no incident report completed or notifications to the doctor or the patient representative. Once the incident report was completed, she would investigate to determine the origin of the bruise and abrasion. Once they find the origin or are unable to find the origin she would follow the provider letter on reportable incidents. The risk to the resident of not having the appropriate notifications done is that there would have been a failure to put interventions in place timely.</p> <p>Interview with Resident #15's responsible party on 3/6/25 at 2:10 pm revealed that she had not been notified of Resident #15's new wound or bruise until a few minutes before the surveyor called. She stated that she was looking through the videos to see if she could see when Resident #15 got the bruise . She stated that she saw Resident #15 on Monday and didn't notice it, and she was looking at video footage from Monday evening to Tuesday morning .</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of facility's policy Change in a Resident's Condition or Status revised May 2017 reflected</p> <p>Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status .</p> <p>The nurse will notify the resident's Attending Physician or physician on call when there has been a(an): a. accident or incident involving the resident; b. discovery of injuries of an unknown source;,,4. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: a. The resident is involved in any accident or incident that results in an injury including injuries of an unknown source; b. There is a significant change in the resident's physical, mental, or psychosocial status; .</p> <p>Review of facility's policy Pressure Ulcers/Skin Breakdown - Clinical Protocol reviewed December 2024 reflected under treatment/management 1. The physician will authorize pertinent orders related to wound treatments, including wound cleansing and debridement approaches, dressings (occlusive, absorptive, etc.), and application of topical agents if indicated for type of skin alteration. 2. The physician will help identify medical interventions related to wound management .</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49427</b></p> <p>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, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 2 of 8 residents (Resident #21 and #64) reviewed, in that:</p> <ol style="list-style-type: none"> <li>1. The facility failed to create and implement a care plan that reflected Resident #21 used chewing tobacco and kept it at bedside.</li> <li>2. The facility failed to create and implement a care plan that reflected Resident #64's right-hand contracture and OT services.</li> </ol> <p>These failures place all residents at risk of not receiving care and services related to their identified needs to maintain or reach their highest practicable physical, mental, and psychosocial well-being.</p> <p>The findings included:</p> <ol style="list-style-type: none"> <li>1. Record review of Resident #21's Comprehensive MDS dated [DATE] revealed he was a [AGE] year-old male admitted to the facility on [DATE], he had a BIMS score of 13 (intact cognition) and the diagnoses of paraplegia (leg paralysis), seizure disorder, and spina bifida (spinal cord defect). Review of Section J- Health Conditions revealed resident did not currently use tobacco.</li> </ol> <p>Record review of Resident #21's care plan, dated initiated 01/31/2025, did not reflect the resident use of tobacco.</p> <p>Observation and interview on 03/04/2025 at 10:09 AM of Resident #21 revealed he was seated in bed watching television with a small tin of Red Seal long cut tobacco (a loose cut smokeless tobacco also known as dip, chewing tobacco, or snuff) and he was spitting a dark brown substance into a diet coke bottle during the interview. He stated that he admitted to the facility with the chewing tobacco and a nurse tried to give him a hard time about it and then the Executive Director came and looked around and no one had talked to him about it since then.</p> <p>In an interview on 03/04/2025 at 12:12 PM with CNA EE she said she was aware Resident #21 used chewing tobacco and stated the DON and the Executive Director were aware.</p> <p>In an interview on 03/05/2025 at 5:20 PM with CNA FF she said she was aware Resident #21 used chewing tobacco and had informed the DON shortly after he first admitted to the facility.</p> <p>In an interview on 03/05/2025 at 6:25 PM with the DON she said she was aware Resident #21 had chewing tobacco. She stated it had been discussed during a meeting with the Executive Director and there was no policy against it so they let him keep it. She was not sure if the resident's use of tobacco was care planned. She stated it probably would not hurt to have it care planned.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 03/06/2025 at 4:44 PM with MDS Coordinator DD she said she was not aware of Resident #21's use of chewing tobacco. She stated it should be care planned to ensure that he is allowed to have it on his person or if it needed to be on the nurse's cart and to ensure he had been counseled to not give it to other residents. She stated it was important for care plans to be person centered and specific to the resident.</p> <p>In an interview on 03/06/2025 at 5:27 PM with the Executive Director she said she was aware Resident #21 had chewing tobacco, the facility was a non-smoking facility and it was not a tobacco that was smoked and was not a vape so there were no concerns. She stated that care plans need to be person centered and they did not think to care plan it at the time. She stated they were going to add it to his care plan. She stated that there was no policy for tobacco use.</p> <p>2. Review of Resident #64's Admission MDS Assessment, dated 12/24/24, reflected she was a [AGE] year-old female with an admitted [DATE]. Resident #64 was moderately cognitively impaired, and her BIMS score was 10. She had impairments on both sides to her upper and lower extremities. She was significantly dependent for most of her ADLs. Resident had the following active diagnoses: Alzheimer's' Disease, Rheumatoid Arthritis (chronic inflammatory disorder usually affecting small joints in the hands and feet), Pain in unspecified joint, Age related Osteoporosis (a condition in which bones become weak and brittle), and Age-related Physical debility.</p> <p>Review of Resident #64's Care Plan revised 7/25/24 revealed .I have (acute/chronic) pain r/t rheumatoid arthritis, sciatica, wedge comp fX T11-T12, osteoporosis Date Initiated: 07/10/2024 The Care Plan did not address issues related to resident's contracture in her right hand or OT services.</p> <p>Review of Resident #64's OT Evaluation and Plan of Treatment dated 6/6/24 reflected the following .RUE ROM=Impaired (impaired ROM of digits and wrist) .</p> <p>Review of Resident #64's OT Evaluation and Plan of Treatment dated 7/22/24 reflected the following .RUE ROM=WFL; LUE ROM=WFL .</p> <p>Observation of Resident #64 on 03/04/25 at 11:06 AM revealed possible contracture to her right hand. She was unable to open her pinky and ring finger when asked to. She had no splint or any other device on the right hand.</p> <p>Interview with CNA V on 3/5/25 at 11:21am revealed that she was unaware if Resident #64 had a contracture.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview and observation with Director of Rehab on 3/5/25 at 2:45 pm revealed that OT had worked with Resident #64 on strengthening, activity tolerance, self-feeding, upper body dressing and oral hygiene. She stated there was no note of contracture at time of discharge. The only recommendation that she saw, was the continued use of build up utensils for all meals to assist with decrease in strength. Resident #64's Range of motion at time of discharge evaluation was within functional limits but does note that she had limited active range to bilateral hands. Director of Rehab observed Resident #64's hands and she stated the left hand looked good, and the right hand had contractions to two fingers (pinky and ring finger) and it was very tight. While Director of Rehab was assessing her hands, Resident #64 stated that her fingers had been that way for a long time. Director of Rehab asked Resident #64 if she would be okay with OT assessing her to see if they could do something with her fingers to help them open some and she stated they could try. Director of Rehab stated that Resident #64's contracture was due to a progression of her arthritis and had not seen anything in her records about the contracture. She reported that Therapy does not update Care Plans and that any updates are usually discussed in the treatment meetings.</p> <p>Interview with Rehab Therapy Assistant CC on 3/6/25 at 9:09am revealed that Resident #64's fingers on her right hand were contracted but that it hurt the resident to do anything with those two fingers. She stated while Resident #64 was in therapy they tried a warm press, but she couldn't tolerate it due to pain. She hadn't tried a splint because Resident #64 would not allow it. She stated therapy was concerned that working with those fingers would affect the other functional fingers. She stated that any recommendation in therapy would be provided to the nurses, and they would have to ensure that the recommendations were followed.</p> <p>Interview with MDS Coordinator DD on 3/6/25 at 4:44pm revealed the Care Plan is updated as needed after every morning meeting. Nurses have the ability to put some acute information in the Care Plans directly and some of the sections of the Care Plan were updated automatically when MDS was completed. Another individual that could update the Care Plans was the social worker. In regard to Resident #59 having had the air mattress as an intervention in her Care Plan and not using it due to her preference, that intervention should have been removed. Regarding Resident #64's contracture, it should have been listed in the Care Plan. She stated she would go in there and correct these two items.</p> <p>Review of Facility's policy, Care Plans, Comprehensive, dated reviewed December 2024, reflected .A Comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .1. The Interdisciplinary Team (IDT) in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident 8. The comprehensive, person centered care plan will: .Describe the services that are to be furnished to attain or maintain the resident's highest practicable, physical, mental and psychosocial well-being; C. Describe services would otherwise be provided for the above, but are not provided due to the residents exercising his or her rights, including the right to refuse treatment .G. incorporate identified problem areas; .J. reflect the resident's expressed wishes regarding care and treatment goals .L. Identify the professional services that are responsible for each element of care M. Aid in preventing or reducing decline in the resident's functional status and/or functional levels N. enhance the optimal functioning of the resident by focusing on a rehabilitative program and O. reflect currently recognized standards of practice for problem areas and conditions .13. Assessment of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change .</p> <p>(continued on next page)</p>		

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F 0656  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	50910

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47690</p> <p>Based on observations, interviews, and record review the facility failed to provide the necessary services for residents who were unable to carry out activities of daily living (ADL) to maintain good grooming and personal hygiene for 2 (Resident #2, Resident #204) of 6 residents reviewed for ADLs.</p> <p>The facility failed to ensure Resident #2 had her fingernails cleaned and trimmed.</p> <p>The facility failed to ensure Resident #204 had showers as care planed three times a week, and as needed.</p> <p>This failure could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections, and a decreased quality of life.</p> <p>Findings included:</p> <p>1. Record review of Resident #2's quarterly MDS assessment, dated 02/11/25, reflected an [AGE] year-old female who was initially admitted to the facility on [DATE], and readmitted on [DATE]. She had a BIMS score of 09/15, which indicated her cognition was moderately impaired. Resident #2 required substantial/maximum assist with ADLs. Resident #2 had diagnoses which included multiple sclerosis (a chronic, autoimmune disease that affects the central nervous system [brain and spinal cord]), dementia (loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), and depression.</p> <p>Record review of Resident #2's care plan, with an onset date of 12/15/24, reflected focus. I have an ADL Self Care Performance Deficit r/t weakness, MS, arthritis. Goal. I will improve current level of function in ADLs through the review date. Intervention. Encourage me to participate to the fullest extent possible with each interaction .</p> <p>An observation on 03/04/25 at 10:37 AM, revealed Resident #2 was laying in her bed. The nails on both hands were approximately 0.3 centimeters in length extending from the tip of her fingers and dirty underneath the nails and around the nail beds. Resident #2 was unable to answer questions related to her fingernail's status.</p> <p>In an interview on 03/05/25 at 09:58 AM, with CNA A she said she was assigned to Resident #2. She stated that most ADLs such as hair trimming and nail clipping were completed during shower times. She revealed that since Resident #2 was not a Diabetic resident, CNAs were responsible for clipping and cleaning her nails. CNA A stated that fingernail clipping should be done weekly or as needed and the risk of not cleaning/trimming fingernails could be increased risk of infection.</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Review of Resident #204's Quarterly MDS assessment dated [DATE] reflected Resident #204 was a [AGE] year-old female with initial admitted to the facility on [DATE], and readmission on 02/27/25. Her diagnoses included cerebrovascular accident (Occurs when blood flow to the brain is interrupted, leading to brain cell death and potential neurological damage.), hemiplegia (paralysis of one side of the body) or hemiparesis (weakness on one side of the body), She had a BIMS score of 12/15, which indicated her cognition was moderately impaired. Further review revealed Resident #204 was dependent on staff for shower/bath.</p> <p>Review of Resident #204's Comprehensive Care Plan, dated 02/27/25, reflected the following: focus. I have an ADL Self Care Performance Deficit r/t developmental social disorders, disease, and debility. Goal. I will maintain current level of function .Personal Hygiene through the review date. Interventions/Task BATHING: I am totally dependent on staff to provide a bath M, W, F and as necessary .</p> <p>Record review of Resident #204's document dated 03/06/2025 titled Task: Bath MWF 6pm-6am changed bed linen revealed Resident #204 received one shower in the lock back 14 days period on 03/06/25 at 02:49 PM , meaning she did not receive a shower on 02/28/25; 03/03/25 and 03/05/25.</p> <p>An observation on 03/04/25 at 11:01 AM, revealed Resident #204 was laying in her bed, wearing a black T-shirt with a V-neck opening. Her visible skin was oily and flaky. Resident #204 stated the last time she had a shower was a week ago during her stay in the hospital.</p> <p>In an interview on 03/06/25 at 06:41 AM, with RN B she said she was assigned to Resident #204 as charge nurse. She stated she did not know that Resident #204 did not receive a shower since she came back from the hospital on 02/27/25. She stated residents were supposed to get showers three times a week, and as needed. She stated CNA s were responsible to give residents showers, clean, and trim their fingernails if the resident was not diabetic. RN B stated CNAs were supposed to let the charge nurse know if the resident refused a shower and the documentation of the shower task. RN B stated the charge nurses were responsible to make sure the CNAs were giving residents their showers timely and cleaning their fingernails. RN B stated the risk to residents was improper hygiene, and possible development of infection if there were any open wounds.</p> <p>In an interview with the DON on 03/06/25 at 09:44 AM, she said her expectation was that residents' showers, unless they ask for specific schedule, should be at least three time a week unless the resident refused. DON stated residents' fingernails should be cleaned and trimmed during the shower days, and as needed. DON stated it was the responsibility of CNAs to give residents shower on time weekly, and the charge nurses in the hall should follow up on residents' ADLs/proper hygiene daily. She stated the risk to residents was development of infection, and loss of dignity .</p> <p>Record review of the facility policy titled Care of Fingernails/Toenails revised December 2024 reflected: Purpose. The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections .General Guidelines. 1.Nail care includes daily cleaning and regular trimming.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility policy titled Shower/Tub Bath revised December 2024 reflected: Purpose. The purpose of this procedure is to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin Documentation. the following information should be recorded on the resident's ADL record and/or in the resident's medical record: 1. The date and time the shower/tub bath was performed. 2. The name and title of the individual (s) who assisted the resident with the shower/tub bath.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34918</p> <p>Based on observation, interview, and record review the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for three of five residents (Resident #98, Resident #34, and Resident #79) reviewed for catheter and incontinence care.</p> <p>1. The facility failed to ensure CNA G and CNA H provided Resident #98 timely and appropriate perineal care after an incontinent episode when they failed to check and change the resident from 06:00 a.m. to 10:25 a.m. and failed to change the surface of the peri-wipes with each stroke on 03/04/25.</p> <p>2. The facility failed to ensure Resident #34, who was being treated for a urinary tract infection, was provided timely incontinence care during the 06:00 p.m. to 06:00 AM shift 03/03/25 to 03/04/25.</p> <p>3. The facility failed to ensure CNA N and CNA O maintained the foley catheter drainage bag below Resident #79's bladder while they transferred the resident with a mechanical lift on 03/05/25.</p> <p>These failures could place residents at risk for not receiving appropriate care to address their incontinence and could increase the risk of urinary tract infections.</p> <p>Findings included:</p> <p>1. Record review of Resident #98's Admission MDS assessment, dated 02/07/25, reflected a [AGE] year-old male with an admitted [DATE]. He had a BIMS of 15, which indicated he was cognitively intact. Resident #98 required substantial/maximum assist with toileting hygiene. He was occasional incontinent of bladder and frequently incontinent of bowel. Resident #98 had diagnoses which included renal insufficiency (poor function of the kidneys), diabetes, cancer, cellulitis (bacterial infection of the skin).</p> <p>Record review of Resident #98's care plan with a revision date of 02/17/25 reflected, I have an ADL Self-Care performance deficit related to disease and debility .Interventions Toilet use: I require extensive assistance of 1 staff participation to use toilet .</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an observation on 03/04/25 at 10:25 a.m. CNA H and CNA G entered Resident # 98's room and asked the resident if he needed changing and he said yes. Both staff put on gloves without performing hand hygiene. CNA H pulled out a packet of peri-wipes and a clean brief from the chest of drawers and uncovered the resident revealing he had brown rings noted on the bed pad. CNA H unfasted the resident's brief revealing it was saturated in urine. CNA H took a peri-wipe and wiped across the resident's pubic area and up and down his penis shaft with several wipes without changing the surface of the wipes. She pushed the saturated brief down toward the residents' buttocks and the staff rolled him onto his side. CNA H then removed the soiled brief and urine-soaked bed pad and threw them on the floor. CNA H then wiped the resident's buttocks front to back without changing the surface of the wipe and then with the same soiled gloves placed a clean brief under the resident. CNA G removed her gloves, left the room without performing hand hygiene and returned with a clean bed pad. CNA G put on clean gloves without performing hand hygiene. CNA H placed the clean bed pad under the resident and then applied barrier cream with the same soiled gloves and wiped the excess onto the clean brief. Both staff members rolled the resident back onto his back and refastened the brief.</p> <p>In an interview with Resident #98 on 03/04/25 at 10:32 a.m. he stated he was last changed yesterday evening but could not remember the time.</p> <p>In an interview on 03/04/25 at 11:45 a.m. with CNA H and CNA G both stated they were supposed to change gloves and perform hand hygiene when they go from dirty before going to clean. CNA H stated she knew she was supposed to change the surface of the wipes each time and was not supposed to throw dirty linen in the floor. She stated she was frustrated since they had found a few residents this morning with brown ringed bed linens. CNA H and CNA G both stated the risk of untimely incontinent care and failing to perform it correctly was urinary tract infections and skin issues.</p> <p>In a follow up interview with CNA H on 03/05/25 at 08:56 a.m. she stated Resident #98 was not her assigned Resident on 03/04/25, but stated she went with CNA G to assist her with turning him. She stated they start making their rounds as soon as they come on shift at 06:00 a.m. She stated there was really no excuse why they were getting in there as late as they were for his first check and change.</p> <p>In a follow up interview on 03/05/25 at 09:35 a.m. with CNA G she stated the reason she was so late getting into Resident #98's room on 03/04/25 was because she was doing a shower on another resident that therapy was wanting up and taken to therapy. She stated he used a urinal usually, but stated he told her he woke up and had been incontinent in his sleep.</p> <p>In an interview on 03/06/25 at 01:50 p.m. with CNA P she stated she worked the 6pm to 6 am shift on 03/03/25-03/04/25. She stated she did not have Resident #98.</p> <p>In an interview on 03/06/25 at 01:55 p.m. with CNA Q she stated she worked on 03/03/25 from 6 pm to 6 am on 03/04/25. She stated she had Resident #98. She stated he had not gone to bed until around 11 p.m. She stated she asked if he needed changing and he told her no. She stated he used a urinal. She stated she helped take his pants and socks off and his brief was dry. She stated she checked on him around 4 a.m. and asked if he needed changing and he told her no. She stated he would usually call them if he needed assistance.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Record review of Resident #34's Admission MDS assessment, dated 02/11/25, reflected an [AGE] year-old female with an admitted [DATE]. She had a BIMS of 12, which indicated she was moderately cognitively impaired. Resident #34 required moderate to substantial/maximum assist with ADLs. She was frequently incontinent of bladder and bowel. Resident #34 had diagnoses which included urinary tract infection, cerebral vascular accident (stroke), Parkinson's disease (disorder of the central nervous system that affects movement) and overactive bladder.</p> <p>Record review of Resident #34's care plan dated 02/05/25 reflected, I have a urinary tract infection . Interventions .Check at least every 2 hours for incontinence. Wash, rinse and dry soiled areas</p> <p>In an interview on 03/04/25 at 11:45 a.m. with CNA H she stated Resident #34 was soaked through her brief and bed pad and it had already started to brown ring when she made her first rounds on her around 08:00 a. m. on 03/04/25. CNA H stated the risk of untimely incontinent care and failing to perform it correctly was urinary tract infections and skin issues.</p> <p>In an interview and observation on 03/04/25 at 02:22 p.m. with Resident # 34 and her family member, the family member was attempting to put the bucket under the potty chair. The family member stated they had to help Resident #34 to the potty chair to prevent her from having an accident. The family member stated it sometimes takes a while before anyone comes to help. The family member stated Resident #34 had a bad night last night. Resident #34 stated she could not get any help. She stated she had put on her call light, and no one came. She stated she called her family member and told them she was sitting in pee and needed to go to bed. The family member stated they called the facility at 7:20 p.m. last night (03/03/25) and asked them to please go and help Resident #34. The family member stated the person who answered the phone stated, yes her call light was on. Resident #34 stated they finally came and put her to bed. She stated she had been sitting in pee forever and was soaked. She stated they came in sometime in the middle of the night to change her but could not remember what time that was. She stated this morning (03/04/25) she was soaked from her head to her toe. She stated the CNAs got her cleaned up this morning.</p> <p>In observation and interview on 03/05/25 at 08:10 a.m. Resident # 34 was observed sitting up in bed finishing breakfast. She stated she had a little better night last night but stated she woke up around 3 am soaked in urine. She stated she called for help, and they did come in and change her. She stated no one had been in yet this morning to change her. She stated she was not sure if she was wet or not.</p> <p>In an observation 03/05/25 at 8:15 a.m. CNA L and CNA K entered Resident #34's room to provide incontinence care. Both staff washed their hands, put on gowns and gloves. CNA L unfastened Resident #34's brief revealing a very red area to her perineal area and down her groin. Resident #34 stated it did not hurt or burn. Resident #34 had thick white paste over the entire area. CNA L wiped numerous times to remove the cream, changing out the wipe with each stroke, but had to resort to soap and water to completely remove the paste. Resident's brief was wet but not saturated. ADON F was alerted to come and observe the resident's skin condition. ADON F stated she would reach out to the doctor. CNAs continued with peri care and rolled the resident onto her side. Residents' buttocks were not as red, and no skin breakdown was observed. Staff completed the incontinence care and applied a clean brief.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 03/05/25 at 08:55 a.m. with CNA H she stated she was assigned Resident # 34 on 03/04/25 on the 6 a.m. to 6 p.m. shift. She stated when she went to check her after breakfast her entire bed, the pad, the sheet everything was wet. She stated her peri area, down her groin and part of her butt were severely red. She stated she took the resident to the shower and pasted her up with zinc oxide. She stated she was not that red the day before.</p> <p>In an interview with CNAs K and L on 03/05/25 at 11:35 a.m. both stated this was their first shift back. Both stated they had not seen Resident #34 with that much redness before. Both stated they did not have any issues with finding residents saturated at shift change.</p> <p>In an interview on 03/06/25 at 01:50 p.m. with CNA P she stated she worked the 6pm to 6 am shift on 03/03/25-03/04/25. She stated she did not have Resident #34. She stated she was assigned to the hall that Resident #34 was on, but she was not allowed to go in her room. She stated the ADON told her last week do not go in her room. She stated she was not sure why the resident did not prefer her.</p> <p>In an interview on 03/06/25 at 01:55 p.m. with CNA Q she stated she worked on 03/03/25 from 6 pm to 6 am on 03/04/25. She stated she remembered being told that Resident # 34's family had called wanting her to be put to bed on the evening of 03/03/25. She stated it was not her hall, but then CNA P told her she could not go into Resident #34's room. She stated she went in and helped her get to bed. She stated she was very wet. She stated she did not know she was assigned to her that night until the call from the Resident's family member and the other aide told her she could not go in the room. She stated after that she went and checked her around 1:30 a.m. and she was soaked. She stated the next time she checked her was around 4:30 am and she was soaked again and had to have a complete bed change. She stated the residents who required incontinent care she tries to do as close to shift change since breakfast comes out about an hour after shift change. She stated she had only taken care of this resident a couple of time. She stated she does not recall if Resident #34 was red, since she does not turn the bright light on to change them during the night shift.</p> <p>In an interview with the DON on 03/06/25 at 02:50 p.m. she stated any resident who was incontinent of bowel and bladder needed to be checked for incontinence every 2 hours and changed as needed. She stated staff were to clean the peri area including penis and scrotum for male residents then move toward the buttocks and change the wipes with each stroke. She stated by not providing accurate incontinent care it placed residents at risk for urinary tract infections, skin breakdown and overall poor hygiene.</p> <p>3. Record review of Resident #79's 5-day Medicare MDS assessment, dated 01/18/25, reflected an [AGE] year-old male with an admitted [DATE]. Resident #79 had a BIMS of 15 which indicated he was cognitively intact. He required moderate assistance for ADL care and had a foley catheter and colostomy (opening in the abdominal wall to divert fecal matter from the colon directly onto the skin) . Active diagnoses included diabetes, morbid obesity, and coronary artery diseases (damage in the heart's major blood vessels).</p> <p>Record review of Resident #79's Physician Order Summary, dated 03/06/25, reflected .Keep urinary drainage bag below the level of the bladder at all times . with a start date of 11/11/24.</p> <p>Record review of Resident #79's care plan, initiated on 11/14/24, reflected, I have indwelling foley catheter . Goal .I will show no s/sx of urinary infection through review date .Interventions .Position catheter bag and tubing below the level of bladder</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an observation on 03/05/25 at 12:40 p.m. CNA N and CNA O entered Resident #79's room to transfer him from his wheelchair to the bed with a mechanical lift. CNA N unhooked the urinary drainage bag from the wheelchair and handed it to the resident to lay in his lap over his bladder. Staff lifted the resident from the wheelchair which tipped him backward causing the urine to back up in the tubing. Resident was lowered onto the bed and repositioned while the urinary drainage bag lay on top of his abdomen. CNA N then placed the drainage bag on the bed rail.</p> <p>In an interview with CNA N and CNA O on 03/05/25 at 12:50 p.m. they both stated they had been taught the urinary drainage bag was to be kept below the bladder. They both stated they were not sure how they were supposed to position the drainage bag during a mechanical lift. They stated the risk of having the urinary bag above the bladder was the back flow of urine which would lead to infection.</p> <p>In an interview with the DON on 03/06/25 at 08:50 a.m., she stated the staff were taught to keep the urinary drainage bag below the bladder to ensure proper drainage and prevent urine from backing up into the bladder and the risk of infection. She stated proper placement of the foley catheter bag during a mechanical lift transfer was not part of their current check off skills, and stated they needed to include this. He stated she and the ADONs did the competency checks on all the CNA staff a few months ago.</p> <p>Record Review of CNA O's Nurse Aide Proficiency skills check off dated 12/18/24 reflected she was competent in the care of indwelling catheters which included keeping the drainage below the bladder.</p> <p>Record Review of CNA N's Nurse Aide Proficiency skills check off dated 12/11/24 reflected she was competent in the care of indwelling catheters which included keeping the drainage below the bladder.</p> <p>Record review of the facility's policy titled, Perineal Care, dated December 2024, reflected, Purpose-The purpose of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition .For male patient .Retract foreskin of the uncircumcised male .Wash and rinse urethral area using a circular motion .continue to wash the perineal area including the penis, scrotum and inner thighs. Do not reuse the same washcloth or water to clean the urethra .Thoroughly rinse perineal area in same order, using fresh water and clean washcloth .Wash and rinse the rectal area thoroughly, including the area under the scrotum, the anus, and the buttocks .Discard disposable items into designated containers .remove gloves .wash and dry hands .</p> <p>Record review of the facility's policy, Catheter Care, Urinary dated June 2018, reflected, The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder .</p>

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NAME OF PROVIDER OR SUPPLIER  Cedar Hollow Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  5011 North US Hwy 75 Sherman, TX 75090	

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34918</p> <p>Based on observations, interviews, and record review, the facility failed to ensure residents received parenteral fluids administered consistent with professional standards of practice and in accordance with physician orders for 1 of 2 residents (Resident #155) reviewed for peripheral intravenous care.</p> <p>The facility failed to ensure Residents #155's PICC line dressing was changed per the physician's order.</p> <p>This failure placed residents at risk of developing an infection.</p> <p>Findings included:</p> <p>Record review of Resident #155's Face sheet dated 03/06/25 reflected a [AGE] year-old-female with an admitted [DATE]. Diagnosis included cellulitis (bacterial infection of the skin).</p> <p>Record review of Resident #155's Admission MDS assessment dated [DATE] reflected a BIMS score of 15 indicating no cognitive impairment. The MDS further revealed Section O: Special Treatments, Procedures, and Programs the resident was receiving IV medications.</p> <p>Record review of Resident #155's Baseline care plan dated 02/21/25 reflected, Reason for admission: Resident had a hospital stay with sepsis, bilateral extremity cellulitis, fall with fracture right ankle- she is toe touching weight bearing as tolerated right leg. IV therapy .Initial goals based on admission orders: Resident would like to have skilled nursing with therapy to improve her overall status and return to prior living condition .Physician Orders: IV orders-MIDLINE Left upper arm .</p> <p>Record review of Resident #155's Physician order summary dated 03/04/25 reflected, Change PICC/Midline dressing using sterile techniques every 7 days and PRN, every day shift every 7 days. With an order date of 02/24/25 and a start date of 02/27/25.</p> <p>Record review of Resident #155's February 2025 MAR/TAR revealed the PICC line dressing was changed on 02/27/25 by ADON I.</p> <p>Review of Resident #155's March 2025 MAR/TAR revealed the PICC line dressing change was due again on 03/06/25.</p> <p>Observation on 03/04/25 at 11:20 a.m. with Resident # 155 revealed she had a PICC line in her left upper arm covered with a transparent dressing. The transparent dressing was dated 02/21/25. No redness, drainage or swelling were observed, and the resident denied any pain at the site of insertion. The Resident stated the PICC line was put in at the hospital right before they sent her to the facility on [DATE]. She stated nobody had changed the dressing since she had been there. She stated she thought she got her last doses of antibiotics yesterday. She stated she was on antibiotics for cellulitis.</p> <p>(continued on next page)</p>

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An observation was made 03/04/25 at 01:45 p.m. of Resident #155's PICC line with ADON I who verified the PICC line dressing was dated 02/21/25 and was past due to be changed.</p> <p>In an interview with ADON I on 03/04/25 at 1:46 p.m. revealed it was her initial on the MAR/TAR on 02/27/25 which indicated the dressing was changed on 02/27/25. ADON I stated she must have signed off on the wrong resident, stating she had not changed Resident #155's PICC line dressing on the 02/27/25. She stated she would make sure the dressing was changed today. She stated the risk of signing off the dressing had been completed, when it had not, put the resident at risk of infection due to the insertion site since the dressing did not get changed within the 7 days as ordered.</p> <p>Interview on 03/05/25 at 08:40 a.m. with ADON F revealed any resident who entered the facility with a PICC line needed to have orders in place for changing the dressing within 7 days or PRN if it became soiled or dislodged. She stated the admission nurse was responsible for putting in the orders, and then she checked behind them. She stated Resident # 155 admitted on Friday (02/21/25). She stated when she reviewed the orders on Monday (02/24/25), she saw the order for dressing changes had been left off, so she obtained the order that day and scheduled the dressing change for 02/27/25 which was 7 days from the initial application of the dressing. She stated the nurses were flushing the line each day before and after administration of medication and should be checking the condition of the dressing which would include looking at the date. She stated even if someone accidentally signed it off in the record as completed, someone should have noticed it was past due to be changed. She stated the risk of not changing the dressing within the specified time frame was infection.</p> <p>Interview on 03/06/25 at 08:50 a.m. with the DON revealed her expectation was for nurses to be checking the PICC lines every shift, flush before and after medication and to change the dressing every 7 days and as needed if soiled. The DON stated the PICC line dressing should be dated. She stated the nurses were responsible for changing and dating the dressings. The DON stated it was the ADON and her responsibility to ensure PICC line dressings were being changed and dated. The DON stated the potential risk of not following physician orders was that it could lead to an infection.</p> <p>Record review of the facility policy Central Venous Catheter Dressing Changes dated December 2024, reflected, The purpose of this procedure is to prevent catheter-related infections that are associated with contaminated, loosened, soiled, or wet dressing Change transparent semi-permeable membrane dressing at least every 5-7 days and PRN (when wet, soiled, or not intact) The following information should be recorded in the resident's medical record .Date and time dressing was changed .</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47690</p> <p>Based on observation, interview, and record review the facility failed to provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing, administering of drugs and biologicals, to meet the needs of each resident for 1 of 4 medication carts (nurses cart hall 100) reviewed for pharmacy services.</p> <p>The facility failed to ensure the Nurses Cart Hall B did not have an expired Tramadol 50 mg HCL table card for Resident #8</p> <p>This failure could place residents at risk of not having the medication available due to possible diminished effectiveness, and not receiving the therapeutic benefits of the medications.</p> <p>Findings Include:</p> <p>Observation and record review on [DATE] at 09:20 AM of nurses' cart Hall B, with LVN D revealed:</p> <ul style="list-style-type: none"> <li>- The medication card of Tramadol HCL 50 mg for Resident#8 with an expiration date of [DATE], and the log for the medication revealed the Resident#8 received the medication 5 time after the expiration date on [DATE], [DATE], [DATE], [DATE] and [DATE].</li> </ul> <p>Interview on [DATE] at 09:57 AM, LVN D stated the count was done at shift change and the count was correct.</p> <p>She stated she did not know when the last time the Nurses' cart for Hall B audit was done. LVN D stated given medication to the residents after it was expired would be ineffective.</p> <p>Interview on [DATE] at 09:44 AM, the DON stated she expected if medication expiration date was passed the medication should be discarded. She stated nurses were responsible for checking the medication expiration date during the count on the change of shifts, and before administering medication to the resident. The DON stated the ADON, and the DON were supposed to check the carts weekly. The DON further stated the pharmacist do random checks monthly of the medication carts for monitoring. The DON stated all the medication had a specific days shelf life and if not thrown out before that time the medication could lose its effectiveness. The DON stated the ADON, and the DON were supposed to do random checks of the medication carts for monitoring.</p> <p>Record review on [DATE] of Resident #8's doctor orders revealed Tramadol 50 mg given 1 tablet by mouth every 6 hours as needed for moderate and severe pain. Order active date [DATE], and modified date [DATE].</p> <p>Record review of the facility policy Storage of medication, dated [DATE], revealed .8. Outdated .medications . are immediately removed from inventory, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34918</p> <p>Based on observations, interviews, and record review the facility failed to ensure that all drugs and biologicals used in the facility were labeled and stored in accordance with professional standards for 5 of 10 Residents (Resident #56, Resident #49, Resident # 98, Resident #155, and Resident #34) and 2 of 4 medication carts (nurses cart Hall A) reviewed for pharmacy services.</p> <ol style="list-style-type: none"> <li>1. The facility failed to ensure the Nurses Cart Hall did not have unsecured medication containers for Resident#56, and Resident#49.</li> <li>2. The facility failed to ensure Resident #155 and Resident #34's anti-fungal powder and were stored properly.</li> <li>3. The facility failed to ensure Resident #34, and Resident #98's Systane eye drops (lubricating drops for dry eye) were stored properly.</li> <li>4. The facility failed to ensure Resident #34 did not have her AM dose of turns left on the bedside table on 03/05/25.</li> </ol> <p>These failures could place residents at risk of medication misuse, not receiving physician ordered medications which could result in non-therapeutic treatments or injuries and ineffective treatment with the use of expired medications.</p> <p>Findings Included:</p> <ol style="list-style-type: none"> <li>1. Observation and record review on 03/04/25 at 09:34 a.m. of nurses' cart Hall A, with RN C revealed: <ul style="list-style-type: none"> <li>- the blister pack for Resident #56's hydrocodone acetaminophen 5-325 mg tablet (controlled medication used for pain) had 1 blister seal broken, the pill still inside the broken blister, and taped.</li> <li>- the blister pack for Resident #49's hydrocodone acetaminophen 10-325 mg tablet (controlled medication used for pain) had 1 blister seal broken, the pill still inside the broken blister, and taped.</li> </ul> </li> </ol> <p>Interview on 03/04/25 at 09:57 a.m., RN C stated the count was done at shift change and the count was correct. She stated she did not check the blister packs during the count. She stated she was unaware when the blister pack seal was broken, and she was not aware of who might have damaged the blister pack. She stated the risk to the residents would be a potential for drug diversion. She stated the nurses were responsible to check the medication blister packs for broken seals during the count of narcotics during the change of the shift. She stated when a broken seal was observed, she would report it to the DON.</p> <p>(continued on next page)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 03/06/25 at 09:44 a.m., the DON stated she expected if a blister pack medication seal was broken the pill should be discarded. The DON stated it would not be acceptable to keep a pill in a blister pack that was opened. The DON stated the risk would be potential for drug diversion and infection control issue. She stated nurses were responsible for checking the medication blister packs for broken seals, and expiration date during the count on the change of shifts. The DON stated the ADONs, and the DON were supposed to check the carts weekly. The DON further stated the pharmacist did random checks monthly of the medication carts for monitoring. The DON stated the ADONs, and the DON were supposed to do random checks of the medication carts for monitoring.</p> <p>2. Record review of Resident #155's face sheet dated 03/06/25 reflected a [AGE] year-old-female with an admitted [DATE]. Diagnosis included cellulitis (bacterial infection of the skin).</p> <p>Record review of a Physician order summary sheet dated 03/04/25 did not reflect an order for antifungal powder.</p> <p>An observation on 03/04/25 at 11:25 a.m. revealed CNA G and CNA H providing incontinence care to Resident #155. After completion of incontinence care, CNA H retrieved a bottle of antifungal powder from the Resident's bedside chest of drawers and applied antifungal powder to the resident's stomach flap and groin area. CNA H then returned the bottle of antifungal powder to the chest of drawers.</p> <p>3. Record review of Resident #98's face sheet dated 03/06/25 reflected a [AGE] year-old male admitted to the facility on [DATE]. Diagnosis included cellulitis (bacterial infection of the skin) and chronic kidney disease.</p> <p>Record review of Resident #98's Physician order summary report dated 03/03/25 did not reflect an order for Systane eye drops.</p> <p>In an observation and interview on 03/04/25 at 10:15 a.m. with Resident #98 revealed a bottle Systane eye drops on his overbed table. Resident #98 stated he brought them with him to the facility and used them occasionally for his dry eyes.</p> <p>In an observation on 03/06/25 at 08:40 a.m. Resident # 98 still had Systane eye drops at bedside on top of a chest of drawers.</p> <p>4. Record review of Resident #34's face sheet dated 03/06/25 reflected an [AGE] year-old female with an admitted [DATE]. Diagnosis included urinary tract infection.</p> <p>Record review of Resident #34's Physician orders summary sheet dated 03/06/25 reflected, Calcium Carbonate Oral Tablet 600 MG (Calcium Carbonate) Give 1 tablet by mouth in the morning .(TUMS). With a start date of 02/23/25. There were no orders for Systane eye drops or antifungal powder.</p> <p>In an observation and interview on 03/05/25 at 08:10 a.m. revealed Resident #34 sitting up in bed finishing breakfast. A bottle of Systane eye drops and a bottle of antifungal powder were observed on the bedside table. Resident #34 stated the eye drops were hers that she brought from home and the facility staff had brought in the powder.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An observation on 03/05/25 at 8:15 a.m. revealed CNA K and CNA L entered Resident # 34's room to provide incontinence care. A white pill approximately the size of a dime and a bottle of Systane eye drops were observed on the Resident's bedside table. CNA L asked the resident if this was her Tums and Resident #34 stated yes, she had not taken it yet this morning. CNA L stated it looked wet, like the resident had put it in her mouth and took it out. CNA L told resident she was going to throw it away. Resident stated OK. CNA L continued to provide incontinence care and once completed, retrieved a bottle of antifungal cream from the resident chest of drawers, and applied it to the resident's buttocks and perineal area.</p> <p>In an interview with CNA H on 03/05/25 at 08:55 a.m. she stated they had access to the antifungal powder in a cabinet behind the nurse's station and they just get it when they need it.</p> <p>In an interview on 03/05/25 at 10:30 a.m. with the DON she stated antifungal powder was considered a medication and should not be at bedside. She stated the antifungal powder was used to treat a condition or as preventive but stated the CNAs did not have the knowledge to make the determination of when to use it. She stated that would be a nursing judgement. She stated they would do a sweep and pull all the antifungal and determine which residents required the antifungal powder. She stated it should be stored in the nursing supply room not the CNA supply rooms.</p> <p>In an interview on 03/05/25 at 11:35 a.m. with CNA K she stated anytime she had needed antifungal powder she would ask the nurse for it. She stated in the past when she had requested it from LVN S, he would tell her the resident had to have a need for it, that they just could not put on without a need. She stated she had seen several residents with antifungal powder in their rooms, but stated she did not use it.</p> <p>In an interview with CNA L on 03/05/25 at 11:32 a.m. she stated she was new to the facility. She stated she had always seen antifungal powder locked up with the nurse's cart in her previous employment and they would have to get it from the nurses. She stated she had seen antifungal powder in the resident's room here, so she assumed it was OK to use.</p> <p>In an interview with LVN R on 03/06/25 at 08:15 a.m. she stated Systane eye drops should not be in Resident # 34's room. She stated she did not have an order for eye drops and she was not aware she had eye drops in her room. She stated the resident's family brought the resident a lot of things from home. She stated she removed the eye drops and reached out to the doctor for an order.</p> <p>In an interview with MA BB on 03/06/25 at 08:25 a.m. she stated she was the assigned MA yesterday (03/05/25) and today (03/06/25) for Resident # 34. She stated she had taken the resident her morning meds on 03/05/25 and the resident had pulled the Tums out of the cup of pills and laid it on the bedside table. She stated the resident would frequently do that and she stated she would tell the resident she had to watch her take it, but the resident would insist on taking it later. She stated she usually threw it away and would come back later and give it to her if she wanted it, but stated she just left it on the table on 03/05/25. She stated she knew she was not to leave medications at the bedside. She stated she had not noticed the Systane eye drops in Resident #34 or Resident #98's rooms. She stated neither one of them had an order for eye drops. She stated eye drops were not supposed to be at bedside.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 03/06/25 at 08:45 a.m. with LVN S he stated antifungal powder was kept in the nursing supply closet he thought. He stated it should not be used unless there was a specific reason for it. He stated everywhere he had worked it was not kept at bedside and the CNAs would request it from the nurses. He stated the nurses needed to know if there was an issue that required the use of antifungal powder so they could assess the area and make sure the CNAs were using it properly. He stated Systane eye drops should not be in the resident's room. He stated he was not aware Resident # 98 had eye drops in his room. He stated the risk of having medications at bedside was another resident could wander in, take something that could hurt them, and or the resident may take a medication that could interact with medications the facility was giving the resident.</p> <p>In a follow up interview with the DON on 03/06/25 at 08:50 a.m. she stated going forward they were going to review all of their barrier products and determine which products the CNAs had access to. She stated they had swept the building and removed all the antifungal powders and were assessing which residents required the use of this of this medication. She stated the eye drops were not to be kept in the resident room. She stated any medication, over the counter or prescription had to have an order and record of administration. She stated this ensured accurate medication administration, review for interactions and to ensure the residents were provided what was ordered by the physician.</p> <p>Record review of the facility policy Storage of medication, dated December 2024, revealed The facility shall store all drugs and biologicals in a safe, secure, and orderly manner .The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed .Drugs for external use, as well as poisons, shall be clearly marked as such, and shall be stored separately from other medications Each resident's medications shall be assigned to an individual cubicle, drawer, or other holding are to prevent the possibility of mixing medications of several residents .</p> <p>47690</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50910</p> <p>Based on observations, interviews, and record review, the facility failed to store, prepare, and serve food in accordance with professional standards for food service safety for the facility's only kitchen.</p> <ol style="list-style-type: none"> <li>1. The facility failed to ensure food items in the facility refrigerator were dated or labeled.</li> <li>2. The facility failed to ensure that food items in the refrigerator were not expired.</li> <li>3. The facility failed to ensure that all canned goods in dry storage were not dented and separated from the other canned goods.</li> </ol> <p>These failures could affect residents who received their meals from the facility's only kitchen, by placing them at risk for food-borne illness if consumed and food contamination.</p> <p>Findings Included:</p> <p>Observation of refrigerator 1 and 2 and interview with Dietary Manager on [DATE] revealed:</p> <p>At 9:19am 3 trays of approximately 36, 8oz clear plastic cups with various brown, beige, and red liquids with no label of what they were, or date served. The Dietary Manager stated the beige liquids were nectar liquid, the brown were tea, and the red were juice. He stated they had just served them in preparation for lunch.</p> <p>At 9:21am a 5lb unopened block of sliced American and Swiss cheese with a received date of [DATE] and manufacture used by date of [DATE]. The Dietary Manager confirmed that it was expired and stated he would throw it away. The risk to the resident if served expired food was that they could be given a compromised product and could affect the residents' health.</p> <p>Observation of dry storage and interview with the Dietary Manager on [DATE] revealed:</p> <p>At 9:32am an unopened 15oz can of [NAME] Taco Fiesta Black Beans, with a ,d+[DATE] of the can dented on the bottom seal. The Dietary Manager stated he would throw it away due to the dent.</p> <p>Interview with the Dietary Manager on [DATE] at 9:35 revealed when they received their shipments, they wrote a received date on the item and put them away. Once items were opened, they wrote a used by date. On condiments and seasonings, they wrote opened date and discard them on the manufacturers best by date. They discarded opened products based on the shelf life of the food and manufactures best buy dates. The dented cans would be removed from dry goods area, placed in his office for a refund request from the manufacture and discarded</p> <p>Interview with Dietary Aide U on [DATE] at 3:01pm revealed that dietary aides and cooks were responsible for labeling food in the refrigerators.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with [NAME] T on [DATE] at 3:03pm revealed that dietary aides were responsible for labeling liquids in refrigerators such as juices, milk, and tea when served. The cooks were responsible for labeling food in refrigerators, freezer, and dry goods area. When items were received, they wrote the date received and date opened on items, the 2nd was the discard date. The second date could also be the open date on items such as seasonings and condiments. The risk to the resident for not labeling items and dating them correctly could result in the resident getting sick from the food provided.</p> <p>Review of facility Policy and Procedure Manual Chapter 3: Food Production and Food Safety dated 2023 revealed .Procedure 12. Leftover food should be stored in covered containers or wrapped in carefully and securely and clearly labeled and dated before being refrigerated. Leftover food must be used within 7 days or discarded as per the 2022 Federal Food Code .13. Refrigerated food storage: .f. All foods should be covered, labeled, and dated and routinely monitored to assure that foods (including leftovers will be consumed by their use by dates, or frozen (where applicable) or discarded .</p> <p>Review of the Food and Drug Administration Food Code, dated 2022, reflected, XXX,d+[DATE].12 Food Storage Containers, Identified with Common Name of Food. Except for containers holding food that can be readily and unmistakably recognized such as dry pasta, working containers holding food, or food ingredients that are removed from their original packages for use in the food establishment, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the food ,d+[DATE]. 11 Food Storage.(B) .refrigerated, ready-to eat time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety</p> <p>Review of Food and Drug Administrative Food Code, dated 2022, reflected, .Chapter 3. Food Condition , d+[DATE].11 Safe, Unadulterated, and Honestly Presented The regulatory community, industry, and consumers should exercise vigilance in controlling the conditions to which foods are subjected and be alert to signs of abuse. FDA considers food in hermetically sealed containers that are swelled or leaking to be adulterated and actionable under the Federal Food, Drug, and Cosmetic Act. Depending on the circumstances, rusted, and pitted or dented cans may also present a serious potential hazard.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>34918</p> <p>Based on observations, interviews, and record review, the facility failed to 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 5 of 12 Residents (Resident #98, Resident #155, Resident #49, Resident #79, and Resident #2) observed for infection control.</p> <ol style="list-style-type: none"> <li>The facility failed to ensure CNA H and CNA G used the required PPE for Resident #98, who was on enhanced barrier precautions due to her venous access device, while providing incontinence care, failed to change gloves and perform hand hygiene during incontinence care and after, and failed to properly handle soiled linens.</li> <li>The facility failed to ensure CNA H and CNA G change gloves and perform hand hygiene during incontinence care to Resident #155 on 03/04/25.</li> <li>The facility failed to ensure CNA M changed her gloves and performed hand hygiene during incontinence care to Resident #49 on 03/05/25.</li> <li>The facility failed to ensure LVN R performed hand hygiene while providing wound care to Resident #79 on 03/05/25.</li> <li>The facility failed to ensure CNA A performed hand hygiene during incontinent care for Resident #2.</li> <li>CNA A failed to perform hand hygiene between food tray delivery and feeding in the dining area on 03/04/25 during meal services and failed to prevent potential food contamination when she handled a resident's bread with bare hands.</li> </ol> <p>These failures could place the residents at risk of cross-contamination and development of infection.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>In an observation and interview on 03/04/25 at 10:15 a.m. Resident #98 had a sign posted outside of his door which indicated enhanced barrier precautions. In an interview with Resident #98, he stated he had been at the facility for about 3 weeks due to issues with his kidneys. He stated he had an access line in his upper right chest. Observed a dressing over a Central Venous line in his upper right chest.</li> </ol> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an observation on 03/04/25 at 10:25 a.m. CNA H and CNA G entered Resident # 98's room and asked the resident if he needed changing and he said yes. Both staff put on gloves without performing hand hygiene and did not put on a gown. CNA H pulled out a packet of peri-wipes and a clean brief from the chest of drawers and uncovered the resident revealing he had brown rings noted on the bed pad. CNA H unfastened the resident's brief revealing it was saturated in urine. CNA H took a peri-wipe and wiped across the resident pubic area and up and down his penis shaft with several wipes without changing the surface of the wipes. She pushed the saturated brief down toward the residents' buttocks and the staff rolled him onto his side. CNA H then removed the soiled brief and urine-soaked bed pad and threw them on the floor. CNA H then wiped the residents buttock front to back without changing the surface of the wipe and then with same soiled gloves placed clean brief under the resident. CNA G removed her gloves, left room without performing hand hygiene and returned with a clean bed pad. CNA G put on clean gloves without performing hand hygiene. CNA H placed the clean bed pad under the resident and then applied barrier cream with the same soiled gloves and wiped the excess onto the clean brief. Both staff members rolled the resident back onto his back and refastened the brief. Both staff removed their gloves, gathered up the dirty linens and trash and left the room without performing hand hygiene.</p> <p>2. In an observation on 03/04/25 at 11:25 a.m. CNA G and CNA H entered Resident #155's room. CNA H stated therapy wanted Resident #155 up and in therapy. Both staff gowned up, washed hands, and put on gloves. CNA H unfastened the resident's brief and wiped across pubic area, down each groin. Rolled resident to her side. CNA G wiped residents' buttocks downward, then changed and wiped from front to back. With the same soiled gloves, placed a clean brief under the resident and then applied barrier cream to her buttocks. While rolling resident back onto her back, the resident stated she was having a bowel movement. The staff rolled her back on her side revealing she had a watery stool. CNA H reached over the resident and wiped the resident from front to back, removed the soiled brief, and with same soiled gloves placed a clean brief under the resident. The staff rolled the resident back onto her back, and CNA H retrieved a bottle of antifungal powder from the bedside chest and applied powder to her stomach flap and groin area, still wearing soiled gloves. Both staff fastened the brief. CNA H then changed her gloves but did not perform hand hygiene. Both staff rolled the resident to place the mechanical sling under her and transferred her to her wheelchair. CNA H pushed the resident to the doorway, removed her gown and gloves, and then retrieved a pair of socks for the resident. CNA H put the resident socks on her and then washed her hands. CNA G finished making the bed, then removed her PPE, and gathered the soiled linen and trash, removed her PPE, and washed her hands.</p> <p>In an interview on 03/04/25 at 11:45 a.m. with CNA H and CNA G both stated they were supposed to change gloves and perform hand hygiene when they go from dirty before going to clean. CNA H stated she knew she was supposed to change the surface of the wipes each time and was not supposed to throw dirty linen on the floor. Both staff stated they looked at the signage on the door to determine what type of precaution to determine what PPE needed to be worn. They stated they just forgot to put the gown on in Resident #98's room. Both stated they had received infection control training on the enhanced barrier precautions and hand hygiene and stated the risk of not following the proper protocol was the spread of germs and infections.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. In an observation on 03/05/25 at 11:45 a.m. during wound care observation with ADON I and CNA M, both staff entered Resident #49's room, put on gown, washed their hands, and put on gloves. ADON I rolled the resident on her side and opened the brief, revealing she had a large soft bowel movement that had oozed up under the wound dressing. ADON I stated they would have to clean her first. ADON I removed the old wound care dressing and wiped away most of the excess bowel movement. ADON I stated she was going to swap places and let CNA M complete the incontinence care. CNA M moved to the opposite of the bed and proceeded to wipe the resident's anal area and buttocks with several wipes, changing the wipes each time. CNA M then removed the soiled brief and placed a clean brief under the resident with soiled gloves. Then she and ADON I rolled the resident onto her back and CNA M wiped down the vagina vault with soiled gloves. CNA M then removed her gloves and re-gloved without performing hand hygiene. ADON I removed her gloves and washed her hands. CNA M entered residents closet to retrieve a clean draw sheet and placed it under the resident. ADON I the performed wound care with no issues of infection control. Both staff removed their PPE and washed their hands.</p> <p>In an interview with CNA M on 03/05/25 at 12:10 p.m. she stated she was supposed change her gloves and perform hand washing when going from dirty to clean. She stated she should have cleaned the resident's front and then rolled her back over to complete the care. She stated the risk was infection control and cross contamination.</p> <p>4. During a wound care observation on 03/05/25 at 01:15 p.m. revealed LVN R entered Resident #79's room to provide wound care to his right and left shin, right foot, and left testicular groin. LVN R put on a gown, washed her hands, and put on gloves. On each wound LVN R changed her gloves after cleaning the wounds but did not perform hand hygiene before re-gloving.</p> <p>In an interview on 03/05/25 at 01:35 p.m. with LVN R she stated she was supposed to perform hand hygiene after every glove change. She stated the risk was cross contamination and spread of infection.</p> <p>5. Observation on 03/05/25 at 9:58 a.m. revealed CNA A entered Resident#2's room to perform incontinence care. CNA A washed her hands, donned gloves. CNA A uncovered Resident#2 and unfastened the resident's brief. CNA A cleaned Resident#2's front area using one wipe per stroke, front to back. CNA A changed gloves without performing hand hygiene, turned Resident#2 to her right side. Resident#2 had a bowel movement. CNA A cleaned the resident's buttocks area using one wipe per stroke, front to back, folded the brief, rolled the under pad over the brief, and pushed both under the resident. CNA A changed gloves without performing hand hygiene, put barrier cream on the resident's buttocks area. CNA A changed gloves without performing hand hygiene. CNA A retrieved a clean pad and brief put them under the resident, and turned her on to her left side, removed the under pad with the dirty brief inside it. CNA A turned resident to her back and finished putting the brief on her. CNA A removed gloves and washed her hands.</p> <p>Interview on 03/05/2025 at 10:26 a.m. CNA A stated the hand sanitizer burns her skin, and she could not use it, but she kept her hands form touching anything. CNA A further stated it was hard to keep going to the bathroom to wash her hands every time she removed the gloves. CNA A declined to answer the question about the risk to the resident. CNA A stated she received training on infection control and resident care two months ago during her orientation.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>6. Observation of CNA A in the dining area on 03/04/25 at 12:21 PM revealed 26 residents waiting for their food tray. CNA A assisted with passing trays out and setting up food for the residents. When the food cart arrived, CNA A carried a tray to a resident, took the dinner roll out of the plastic bag with her bare hands, and put it on the resident's plate. She then went back to the cart picked up another tray, took the dinner roll out of the plastic bag with her bare hands, and placed in on another resident's plate. She went back to the food cart a 3rd time, got a tray, took it to a resident, placed it on the table, took the dinner roll out of the plastic bag, and placed it on the resident's plate. CNA A then washed her hands and waited for more trays to be put on the cart. CNA A, touched her clothes, put her hands on her hips, pulled her pants up while waiting, and then got a food tray from the cart, took the bread out of the plastic bag with her hands, and placed it on the resident's plate. She went to the cart and grabbed another tray and placed it on the table in front of a resident. CNA A then went to a resident who already had a tray, moved the resident's tray to a different area on the table, moved the resident in his wheelchair where his food tray was at, sat next to him, and fed him his food. She continued to feed him until he was done and pushed him in his wheelchair back to his room.</p> <p>Interview with CNA A on 3/4/25 at 1:08pm revealed her task was to deliver food trays to the residents in the dining area and set their food up as needed. She acknowledged that that she had not washed or sanitized her hands after delivering every tray. She stated the hand sanitizer was irritating to her skin, so she preferred to wash her hands instead. She stated the requirement was, she should be washing or sanitizing her hands between every tray delivery. The risk to residents for not washing hands would be the possibility of cross contamination that could result in them getting sick. She indicated if you touched your clothes, surfaces, or body parts after washing or sanitizing then you should wash/sanitize again to avoid cross contamination.</p> <p>Interview with CNA V on 3/5/25 at 11:08am revealed CNAs should have washed their hands before they begun passing trays and hand wash or sanitize between each tray delivery to prevent the spread of germs.</p> <p>Interview with CNA M on 3/5/25 at 11:42am revealed CNAs should wash their hands before they started passing out trays and wash hands or sanitize after each tray was delivered to prevent the spread of germs.</p> <p>Interview with CNA W on 3/5/25 at 12:08pm revealed when passing food trays, she would wash her hands before touching the trays, take a tray to a resident, tell them what's on the tray, set the food up, if necessary, then hand sanitize before getting another tray for infection control.</p> <p>Interview on 03/06/25 at 07:35 AM ADON E, revealed she expected CNAs to change gloves and perform hand hygiene before putting on the clean gloves. She stated if CNA A could not use the alcohol-based hands sanitizer she would like her to wash her hands. She stated she just find out that CNA A was allergic to the hand sanitizer and asked her to use proper hand hygiene when taking care of the residents. The ADON E stated the risk to residents was infection control, and cross contamination.</p> <p>Interview on 03/06/2025 at 09:49 AM with the DON, revealed she expected staff to change gloves and wash their hands before care, when they went from dirty to clean, and after care was completed. She stated enhanced barrier precautions were noted on each resident who required extra PPE and expected the staff to always follow it. She stated the risk to residents was developing infection.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with ADON E on 3/6/25 at 9:51am revealed her expectation for hand hygiene for staff passing out trays was for them to hand wash or hand sanitize every 3rd tray, unless hands become soiled, or they touched a resident's belongings or their own belongings.</p> <p>Interview with the DON on 3/6/25 at 12:18pm revealed that staff should have used sanitizer on their hands between delivery of every tray. The risk of not sanitizing or washing hands between delivery of trays was cross contamination of the next tray.</p> <p>Record review of the facility's policy, Enhanced Barrier precautions, dated December 2024, reflected, Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug resistance organisms that employs targeted gown and glove use during high contact resident care activities. EBP are used in conjunction with Standard Precautions and expand the use of PPE, to donning gown and glove use during high contact resident care activities that provide opportunities for transfer of MDROs to staff hand and clothing Enhanced Barrier Precautions include following practices . hand hygiene .gloves .Eye protection, face Shields .gowns .</p> <p>Record review of the Facility's policy Handwashing/Hand Hygiene revised August 2015 .Policy Interpretation and Implementation .7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations .b. before and after direct contact with residents .g. Before handling clean or soiled dressing, gauze pad .H. Before moving from a contaminated body site to a clean body site during resident care .k. After handling used dressing. Contaminated equipment .l. after contact with objects (e.g., medical equipment) in the immediate vicinity of the resident .m. After removing gloves .o. before and after eating or handling food; p. before and after assisting a resident with meals .Hand hygiene is the final step after removing and disposing of personal protective equipment .The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections .</p>		