

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676109	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/17/2024
NAME OF PROVIDER OR SUPPLIER  Calder Woods		STREET ADDRESS, CITY, STATE, ZIP CODE  7080 Calder Beaumont, TX 77706	

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 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** 47879</b></p> <p>Based on interviews and record review, the facility failed to immediately notify the resident physician regarding a change in a resident's condition for one (Resident #1) of seven residents reviewed for changes in condition.</p> <p>The facility failed to inform the physician immediately of Resident #1's witnessed fall on 12/15/2023.</p> <p>This failure could place residents' physician at risk of not being aware of any changes in their conditions and could result in a delay in treatment and a decline in residents' health and well-being.</p> <p>The findings included:</p> <p>Record review of Resident #1's face sheet dated 10/15/24 indicated an [AGE] year-old female with an admitted [DATE] with diagnoses of Alzheimer's disease unspecified, muscle weakness (Generalized), and other abnormalities of gait and mobility.</p> <p>Record review of Resident #1's Admission MDS dated [DATE] indicated she was understood and understood others and she had a moderate cognitive impairment (BIMS score of 6). She required supervision or moderate assistance for most ADLs. She had at least one fall in the last month prior to admission/entry or reentry to the facility. She was frequently incontinent of bladder and occasionally incontinent of bowel.</p> <p>Record review of Resident #1's care plan, revised on 11/12/2023, indicated the resident had a history of falls since admission related to poor safety awareness due to Alzheimer's. The interventions included to engage resident in activities that improve strength, balance, and posture as tolerated and document results, keep nurse call bell within easy reach or instruct resident to use call bell or call out for assistance, instruct resident on safety measures to reduce the risk of falls, keep areas free of obstructions to reduce the risk of falls or injury, keep personal items within reach, and the bed was to be in low position with wheels locked.</p> <p>Record review of the facility's Incident/Accident Log dated 12/01/2023 through 12/31/2023 indicated no history of falls for Resident #1. Incident log indicated an injury of unknown origin reported on 12/19/2023.</p> <p>(continued on next page)</p>

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676109	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/17/2024
NAME OF PROVIDER OR SUPPLIER  Calder Woods		STREET ADDRESS, CITY, STATE, ZIP CODE  7080 Calder Beaumont, TX 77706	
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record Review of Resident #1's incident report dated 12/19/2023 authored by LVN A indicated that the nurse noted resident to have bruising and swelling to the right eyebrow area while sitting in her wheelchair in the common area, resident said I'm fine and denied any pain or discomfort.</p> <p>Record review of Resident #1's progress notes reviewed from 12/01/2023 through 12/31/2023 found no progress notes or incident reports indicating Resident #1 was assessed by LVN C for injuries following a witnessed fall observed by CNA B on 12/15/2023 and/or documentation that the physician was notified of the witnessed fall.</p> <p>Resident #1, no longer resides at facility, attempted to call Resident #1 and/or FM via telephone on 10/16/2024 at 5:15 p.m. and 6:15 p.m., attempts were unsuccessful with no answered or returned phone calls.</p> <p>During an interview on 10/16/2024 at 10:00 a.m., the Executive Director said she was the administrator at the time of the incident with Resident #1. During her investigation with the report of Resident #1 having an injury of unknown origin on 12/19/2023, she found that Resident #1 had a witnessed fall observed by CNA B on 12/17/2023. This was reported to LVN C, but she failed to complete an incident report and/or document in the resident's medical records regarding the fall. She said that the incident happened at shift change and due to poor communication (on coming shift thought out going shift was notified and aware of the incident) the incident was not documented. She said the staff were provided an in-service regarding completing incident reports and reporting incidents to physicians. She said not reporting changes to the physician could result in a delay in resident's treatment.</p> <p>During an interview on 10/16/2024 at 4:52 p.m., LVN A said on 12/19/2023 she noticed bruising and swelling to Resident #1's right eye/eyebrow area. She said Resident #1 did not show grimace or signs of pain at that time. She said she completed an incident report for injury of unknown origin and incident was reported immediately to the DON, the AC, the MD, and the RP. LVN A said that Resident #1 had a history of falls, and that the MD did not give any new orders when the fall was reported on 12/19/2023. She said during interviews and conversations with other staff and the family it was later found that the resident had a witnessed fall observed by CNA B on 12/17/2023 which could have caused the bruise and swelling to Resident #1's right eye/eyebrow area. LVN A said she had received training on reporting incidents to the the NP/MD and completion of incident reports.</p> <p>CNA B, no longer employed at the facility, was attempted to be reached via telephone on 10/16/2024 at 5:00 p.m. and 6:00 p.m., attempts were unsuccessful with no answered or returned phone calls.</p> <p>Record review of a witness statement provided by CNA B indicated on 12/17/2023 at around 6:10 p.m., CNA B was arriving to work. Resident #1 requested CNA B take her to the restroom. CNA B assisted Resident #1 to the restroom, and when she was finished in the restroom, she assisted her to her wheelchair and started wheeling her back to the sitting area. Resident #1 said she had forgotten her purse in the restroom and asked CNA B to retrieve her purse for her. CNA B returned to the restroom to retrieve the purse, and when she was coming out of the restroom, she observed Resident #1 standing up from her wheelchair and falling. and CNA B ran to her and attempted to reach her to prevent a fall but was unsuccessful, and Resident #1 fell , hitting the side of her forehead. CNA B stated Resident #1 was getting herself up, saying nothing happened. Resident #1 was assisted back in her wheelchair, and LVN C was notified of the incident.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676109	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/17/2024
NAME OF PROVIDER OR SUPPLIER  Calder Woods		STREET ADDRESS, CITY, STATE, ZIP CODE  7080 Calder Beaumont, TX 77706	
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/17/2024 at 10:45 a.m., LVN C said when she began her shift at 6:00 p.m. on 12/17/2023, CNA B reported to her that Resident #1 had a fall or near fall. LVN C said she conducted a head-to-toe assessment after CNA B reported the incident and she did not observe any injuries nor did the resident grimace or make sounds of pain when she was assessing her. LVN C said Resident #1's family and private sitter were present during the assessment and was aware of the fall/near fall incident and made light of the situation (no concerns). She said that she initially thought the incident had happened on the prior shift and the other shift had completed the incident report and documentation. She said she got busy during her shift and failed to review the chart for the incident report or document the head-to-toe assessment she completed. LVN C said she was later questioned about the incident, and it was found that Resident #1 fell at shift change and that she was responsible for completing the incident report and reporting the incident to the physician, which she failed to do. She said she received training on completing incident reports and notifying the physician of accidents/injuries. She said not reporting incidents to the physician could delay the resident's treatment.</p> <p>During an interview on 10/17/2024 at 2:30 p.m., the interim DON said she had only been at the facility for a little over a week as interim DON, but her expectations were if a resident had a fall that the resident be assessed immediately by licensed facility staff and the fall and assessment findings be reported to the MD/NP, the ADON, herself, the Administrator, and the RP, if applicable. The DON said that the NP/MD would dictate what happened next with new orders (x-rays, to local ER for evaluation, medications). The DON said the facility staff should initiate the incident reporting process (incident report, neuro checks, changes, skin assessments, etc.) and document for 72 hours in the resident electronic medical records to identify any changes/concerns. The DON said staff should make sure all incident care and follow up care was documented in the resident's medical record. The DON said that not reporting the incident to MD/NP could delay the resident's treatment plan.</p> <p>During an interview on 10/17/2024 at 3:00 p.m., the Administrator said that he had only been the interim Administrator for about one week, but his expectation was if a resident had a fall that the resident would be assessed immediately by licensed staff and the fall assessment would be reported to the physician/NP, the family, and the supervisor. The facility licensed staff should initiate the incident reporting process and document all findings in the resident's electronic medical record. The Administrator said that the electronic medical records should include an incident report, clinical documentation, who was notified of the incident, and complete documentation of the incident. The Administrator said that the resident involved in the incident should be assessed routinely until resolution and follow up from physician received. The Administrator said that not reporting the incident to MD/NP could delay the resident's treatment.</p> <p>Record Review of Facility's In-Service Training Report Titled January Nursing Meeting dated 01/25/2024 indicated, Incident reports: All incident reports need to be done immediately when an incident occurs. This includes the entire incident process including risk assessments, neuro checks (if the fall is unwitnessed and the patient is unable to tell you if they hit their head or not neuro checks must be started.) Every shift is responsible for completing your section on the report.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676109	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/17/2024
NAME OF PROVIDER OR SUPPLIER  Calder Woods		STREET ADDRESS, CITY, STATE, ZIP CODE  7080 Calder Beaumont, TX 77706	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0580  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Record review of the facility's Notification of Changes policy, revised July 16, 2024, indicated 1. The nurse will immediately notify the resident/resident responsible representative (consistent with his/her authority) and physician for the following changes (this list is not all inclusive) an accident involving residents, which result in injury and has the potential for requiring physician intervention . 2. The nurse will notify the resident/resident's representative and the resident's physician for non-immediate changes of condition in a timely manner 3. Document the notification and record any new orders in the resident's medical records .		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676109	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/17/2024
NAME OF PROVIDER OR SUPPLIER  Calder Woods		STREET ADDRESS, CITY, STATE, ZIP CODE  7080 Calder Beaumont, TX 77706	
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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47879</b></p> <p>Based on interviews and record review, the facility failed to ensure the medical record was complete and accurately documented for 1 of 8 residents (Resident #1) reviewed for resident records.</p> <p>The facility failed to ensure LVN C documented Resident #1's change of condition and physician notification on 12/17/2023.</p> <p>This failure could place residents at risk for delayed care and appropriate interventions.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet dated 10/15/24 indicated an [AGE] year-old female with an admitted [DATE] with diagnoses of Alzheimer's disease unspecified, muscle weakness (Generalized), and other abnormalities of gait and mobility.</p> <p>Record review of Resident #1's Admission MDS dated [DATE] indicated she was understood and understood others and she had a moderate cognitive impairment (BIMS score of 6). She required supervision or moderate assistance for most ADLs. She had at least one fall in the last month prior to admission/entry or reentry to the facility. She was frequently incontinent of bladder and occasionally incontinent of bowel.</p> <p>Record review of Resident #1's care plan, revised on 11/12/2023, indicated the resident had a history of falls since admission related to poor safety awareness due to Alzheimer's. The interventions included to engage resident in activities that improve strength, balance, and posture as tolerated and document results, keep nurse call bell within easy reach or instruct resident to use call bell or call out for assistance, instruct resident on safety measures to reduce the risk of falls, keep areas free of obstructions to reduce the risk of falls or injury, keep personal items within reach, and the bed was to be in low position with wheels locked.</p> <p>Record review of the facility's Incident/Accident Log dated 12/01/2023 through 12/31/2023 indicated no history of falls for Resident #1. Incident log indicated an injury of unknown origin reported on 12/19/2023.</p> <p>Record Review of Resident #1's incident report dated 12/19/2023 authored by LVN A indicated that the nurse noted resident to have bruising and swelling to the right eyebrow area while sitting in her wheelchair in the common area, resident said I'm fine and denied any pain or discomfort.</p> <p>Record review of Resident #1's progress notes reviewed from 12/01/2023 through 12/31/2023 found no progress notes or incident reports indicating Resident #1 was assessed by LVN C for injuries following a witnessed fall observed by CNA B on 12/15/2023 and/or documentation that the physician was notified of the witnessed fall.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676109	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/17/2024
NAME OF PROVIDER OR SUPPLIER  Calder Woods		STREET ADDRESS, CITY, STATE, ZIP CODE  7080 Calder Beaumont, TX 77706	
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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/16/2024 at 10:00 a.m., the Executive Director said she was the administrator at the time of the incident with Resident #1. During her investigation with the report of Resident #1 having an injury of unknown origin on 12/19/2023, she found that Resident #1 had a witnessed fall observed by CNA B on 12/17/2023. This was reported to LVN C, but she failed to complete an incident report and/or document in the resident's medical records regarding the fall. She said that the incident happened at shift change and due to poor communication (on coming shift thought out going shift was notified and aware of the incident) the incident was not documented. She said the staff were provided an in-service regarding completing incident reports and reporting incidents to physicians. She said not reporting changes to the physician could result in a delay in resident's treatment.</p> <p>During an interview on 10/16/2024 at 4:52 p.m., LVN A said on 12/19/2023 she noticed bruising and swelling to Resident #1's right eye/eyebrow area. She said Resident #1 did not show grimace or signs of pain at that time. She said she completed an incident report for injury of unknown origin and incident was reported immediately to the DON, the AC, the MD, and the RP. LVN A said that Resident #1 had a history of falls, and that the MD did not give any new orders when the fall was reported on 12/19/2023. She said during interviews and conversations with other staff and the family it was later found that the resident had a witnessed fall observed by CNA B on 12/17/2023 which could have caused the bruise and swelling to Resident #1's right eye/eyebrow area. LVN A said she had received training on reporting incidents to the the NP/MD and completion of incident reports.</p> <p>CNA B, no longer employed at the facility, was attempted to be reached via telephone on 10/16/2024 at 5:00 p.m. and 6:00 p.m., attempts were unsuccessful with no answered or returned phone calls.</p> <p>Record review of a witness statement provided by CNA B indicated on 12/17/2023 at around 6:10 p.m., CNA B was arriving to work. Resident #1 requested CNA B take her to the restroom. CNA B assisted Resident #1 to the restroom, and when she was finished in the restroom, she assisted her to her wheelchair and started wheeling her back to the sitting area. Resident #1 said she had forgotten her purse in the restroom and asked CNA B to retrieve her purse for her. CNA B returned to the restroom to retrieve the purse, and when she was coming out of the restroom, she observed Resident #1 standing up from her wheelchair and falling. and CNA B ran to her and attempted to reach her to prevent a fall but was unsuccessful, and Resident #1 fell , hitting the side of her forehead. CNA B stated Resident #1 was getting herself up, saying nothing happened. Resident #1 was assisted back in her wheelchair, and LVN C was notified of the incident.</p> <p>During an interview on 10/17/2024 at 10:45 a.m., LVN C said when she began her shift at 6:00 p.m. on 12/17/2023, CNA B reported to her that Resident #1 had a fall or near fall. LVN C said she conducted a head-to-toe assessment after CNA B reported the incident and she did not observe any injuries nor did the resident grimace or make sounds of pain when she was assessing her. LVN C said Resident #1's family and private sitter were present during the assessment and was aware of the fall/near fall incident and made light of the situation (no concerns). She said that she initially thought the incident had happened on the prior shift and the other shift had completed the incident report and documentation. She said she got busy during her shift and failed to review the chart for the incident report or document the head-to-toe assessment she completed. LVN C said she was later questioned about the incident, and it was found that Resident #1 fell at shift change and that she was responsible for completing the incident report and reporting the incident to the physician, which she failed to do. She said she received training on completing incident reports and notifying the physician of accidents/injuries. She said not reporting incidents to the physician could delay the resident's treatment.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676109	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/17/2024
NAME OF PROVIDER OR SUPPLIER  Calder Woods		STREET ADDRESS, CITY, STATE, ZIP CODE  7080 Calder Beaumont, TX 77706	
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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/17/2024 at 2:30 p.m., the interim DON said she had only been at the facility for a little over a week as interim DON, but her expectations were if a resident had a fall that the resident be assessed immediately by licensed facility staff and the fall and assessment findings be reported to the MD/NP, the ADON, herself, the Administrator, and the RP, if applicable. The DON said that the NP/MD would dictate what happened next with new orders (x-rays, to local ER for evaluation, medications). The DON said the facility staff should initiate the incident reporting process (incident report, neuro checks, changes, skin assessments, etc.) and document for 72 hours in the resident electronic medical records to identify any changes/concerns. The DON said staff should make sure all incident care and follow up care was documented in the resident's medical record. The DON said that not reporting the incident to MD/NP could delay the resident's treatment plan.</p> <p>During an interview on 10/17/2024 at 3:00 p.m., the Administrator said that he had only been the interim Administrator for about one week, but his expectation was if a resident had a fall that the resident would be assessed immediately by licensed staff and the fall assessment would be reported to the physician/NP, the family, and the supervisor. The facility licensed staff should initiate the incident reporting process and document all findings in the resident's electronic medical record. The Administrator said that the electronic medical records should include an incident report, clinical documentation, who was notified of the incident, and complete documentation of the incident. The Administrator said that the resident involved in the incident should be assessed routinely until resolution and follow up from physician received. The Administrator said that not reporting the incident to MD/NP could delay the resident's treatment.</p> <p>Record Review of Facility's In-Service Training Report Titled January Nursing Meeting dated 01/25/2024 indicated, Incident reports: All incident reports need to be done immediately when an incident occurs. This includes the entire incident process including risk assessments, neuro checks (if the fall is unwitnessed and the patient is unable to tell you if they hit their head or not neuro checks must be started.) Every shift is responsible for completing your section on the report.</p> <p>Record review of the facility's Notification of Changes policy, revised July 16, 2024, indicated 1. The nurse will immediately notify the resident/resident responsible representative (consistent with his/her authority) and physician for the following changes (this list is not all inclusive) an accident involving residents, which result in injury and has the potential for requiring physician intervention . 2. The nurse will notify the resident/resident's representative and the resident's physician for non-immediate changes of condition in a timely manner 3. Document the notification and record any new orders in the resident's medical records .</p>		