Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 03/27/2025
Form Approved OMB
No. 0938-0391

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 01/07/2025
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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25115 Based on interview 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. The facility failed to document a physician ordered x-ray was completed, the results, or physician notification in Resident #1's medical record. This failure could place residents at risk for delayed care and appropriate interventions. Findings included: Record review of Resident #1's face sheet dated 01/06/24 indicated she was a [AGE] year old female, admitted on [DATE], and her diagnoses included dementia (decline in cognitive function), pleural effusion (collection of fluid around the lungs), wheezing (high pitched whistle sound made when breathing), delirium due to know physiological condition, atrial fibrillation (abnormal heart rhythm), insomnia (sleep disorder), and anxiety (excessive, persistent, and uncontrollable worry and fear about everyday situations). Record review of Resident #1's quarterly MDS dated [DATE] indicated she was able to make herself understood, usually understood others, and had moderate cognitive impairment (BIMS 9). She used a walker or wheelchair for mobility. She required assistance for all ADLS. She received oxygen therapy. Record review of Resident #1's care plan dated 10/01/24 indicated she had potential for distressed respiratory effort due to SOB. Interventions included check O2 saturations and notify MD if outside parameters. Record review of Resident #1's physician orders dated 10/16/24 indicated O2 at 2-4 L/min per nasal cannula PRN. Record review of Resident #1's physician orders dated 12/31/24 indicated chest x-ray 2 views. (continued on next page)

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

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's physician note dated 12/31/24 and completed by NP C indicated Resident #1 developed a wet cough this morning. Review of systems indicated breathing problems, cough, and shortness of breath with exertion. O2 SAT 97%. Assessments indicated cough and chronic congestive heart failure. Treatment included chest x-ray and continue Furosemide Tablet 40 MG 1 tablet orally once a day. Record review of Resident #1's x-ray report dated 12/31/24 at 7:17 p.m. indicated right base infiltrate (white opacity(lacking transparency) in the lungs) and effusion (abnormal collection of fluid), worse than prior. Record review of fax confirmation sheet dated 01/01/25 at 10:54 a.m. indicated LVN A faxed Resident #1's x-ray report to the MD B for review. Record review of fax confirmation sheet dated 01/01/25 at 10:56 a.m. indicated LVN A faxed Resident #1's x-ray report to the MD B for review. Record review of Resident #1's clinical notes dated 12/31/24 through 01/02/25 indicated no documentation of physician notification of change of condition and SOB, physician ordered chest x-ray, completion of chest x-ray, results of x-ray or sending results to the physician for review. During an interview on 01/06/25 at 12:10 p.m., LVN A said Resident #1 had a change of condition on 12/31/24 with SOB and NP C ordered chest x-rays. She said the x-rays were completed on 12/31/24 but the results were not received in the facility before she left at 6:00 p.m. She said she returned to the facility on [DATE] and found the results in the portal. She said she faxed the results to the provider's two separate fax numbers and received confirmations the faxes were successful. She said she called the on-call NP and left a message regarding Resident #1's x-ray results. She said she could not recall the on-call NP's name. She said she put the fax confirmation and x-ray results in the binder at the nurse station for physician review. She said she spoke with the RP and showed her the x-ray results. She said the RP did not want Resident #1 sent out to hospital and was in process of considering hospice. She said on 01/02/25 Resident #1 was receiving her O2 via nasal cannula and also received her breathing TX as ordered. She said the x-ray results were still in the binder at the nurse station waiting for physician review. She said it was her error she did not document in Resident #1's chart for 12/31/24, 01/01/25 and 01/02/25. She said Resident #1 was at risk of not receiving care and services when there was missing information in the clinical records. During an interview on 01/07/25 at 11:30 a.m., RD D said she was conducting a clinical chart audit and was not able to determine if Resident #1's physician ordered x-ray was completed. She said she was not able to determine if the x-ray results were received or if the physician was notified of the results because there was no documentation in Resident #1's chart. She said she called the facility on 01/03/25 and directed MDS LVN E to determine if the x-ray was completed, locate the results, and complete a focused assessment of Resident #1. She said MDS LVN E located the x-ray results by the fax machine, conducted a focused assessment of Resident #1 and notified NP C of the results. She said she was not aware the results of the x-ray were available to the facility as of 12/31/24. She said she was not aware LVN A obtained the results from the portal on 01/01/25 or faxed the results to MD B. She said there was no documentation in Resident #1's medical record. She said it was the facility's expectations the nurse on duty would document a physician ordered x-ray was completed, the results, and physician notification in Resident #1's medical record. She said residents were at risk of delayed care or untimely interventions if there was incomplete documentation in the medical record. (continued on next page)

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	676109	A. Building B. Wing	01/07/2025

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Calder Woods	7080 Calder Beaumont, TX 77706

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy Charting and Documentation dated 10/11/21 indicated Documentation in the medical record is primarily electronic; however, there may be some manual documents that are uploaded into the record. 1. The following information is to be documented in the resident's medical record: a. Objective observations; b. Medications administered; c. Treatments or services performed; d. Changes in the resident's condition; e. Events, incidents, or accidents involving the resident; and f. Progress toward or changes in the care plan goals and objectives. 2. Documentation in the medical record will be objective (not opinionated or speculative), complete and accurate. 3. Entries may only be recorded in the resident's clinical record by licensed personnel (e.g., RN, LVN, physicians, therapists, social workers, administrator, etc.) in accordance with state law and (named facility) service standards. 5. Per (named facility) expectations, the clinical record must contain per shift charting of resident's condition for a minimum of 3 days following incidents. 6. Per (named facility) expectations, the clinical record should include follow-up of resident's condition at least daily while a resident is on antibiotics or antiviral medication. 7. While long term care charting is by exception, it must include all assessments and unexpected outcomes to reflect thorough nursing care of the resident. 9. Documentation of procedures and treatments will include care-specific details, including: a. The date and time the procedure/treatment was provided; b. The name and title of the individual(s) who provided the care; c. The assessment data and/or unusual findings obtained during the procedure/treatment; d. how the resident tolerated the procedure/treatment; e. Whether the resident refused the procedure/treatment; f. Notification of family, physician, or other staff, if indicated; and g. the signature and title of the individual documenting.