

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 08/11/2025
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)
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure that residents requiring respiratory care were provided such care, consistent with professional standards of practice for 1 of 2 (Resident #2) residents who were reviewed for respiratory care. 1. The facility failed to ensure Resident #2 had orders for her oxygen therapy. 2. The facility failed to ensure Resident #2's oxygen humidifier was changed when emptied. This failure could place residents who receive respiratory care at risk of developing respiratory complications and a decreased quality of care. The findings included: Record review of Resident #2's face sheet, dated 08/11/25, indicated she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included anxiety disorder, hypertension (high blood pressure), and unsteadiness on feet. Record review of Resident #2's Comprehensive MDS assessment, dated 08/06/25, indicated Resident #2 had a BIMS score of 15 indicating she was cognitively intact. Resident #2's Special Treatment, Procedures, and Programs under Respiratory Treatments did not have oxygen therapy checked. Record review of Resident #2's care plan, dated 08/11/25, reflected it had no respiratory treatment or care included. Record review of Resident #2's physician orders reviewed on 08/11/25 prior to an interview with LVN A, did not indicate any orders for oxygen therapy or related care. Orders were added immediately after the interview with LVN A. During an observation and interview on 08/11/25 at 08:56 AM, Resident #2 was in her bed with her breakfast in front of her. Her nasal cannula was in her nostrils. The oxygen humidifier bottle was dated 08/02/25, was initialed, and was empty. She stated, They act like they don't even know I am on one (humidifier). She stated, they forget to check it. I have to remind them to change it. She stated, One night nurse has something was buzzing when she came in. She stated, How would it affect me? when asked if it affected her to not have the humidifier changed timely. During an observation on 08/11/25 at 12:01 PM, the oxygen humidifier was still empty, and Resident #2 continued to wear her nasal cannula. During an observation and interview on 08/11/25 at 12:57 PM, Resident #2 asked LVN A if it (oxygen humidifier) was bubbling. LVN A stated, No, the water ran out. I have to get another one. LVN A stated the night shift changed the oxygen humidifier weekly or PRN if it was empty. LVN A stated the risk of not replacing the oxygen humidifier timely could be nose bleeds, shortness of breath, or dry sinuses. LVN A went to the computer to look up Resident #2's orders. She stated there were no orders for her oxygen therapy. She stated, I will put them in now. She stated the nurse that admitted her was responsible for ensuring the orders were in place. She stated the risk to the resident was that the respiratory equipment might not be changed out which could lead to infection. During an interview on 08/11/25 at 1:25 PM, the DON said nursing staff and nursing administration were responsible to ensure orders were in place. The DON stated the oxygen humidifier should be replaced when the water was out or weekly. The DON stated not changing the oxygen humidifier when it was empty could cause dry mucous membranes. The DON stated not having accurate orders in place could cause a change in condition for the resident. Requested Respiratory Care In-services from the DON on 08/11/25 at 1:25 PM, none were provided before exit. Record review of the facility policy titled, Respiratory Services dated 01/07/25 indicated, Service standard; healthcare personnel will provide respiratory care in compliance with current standards of practice. Respiratory services may include oxygen administration. Respiratory equipment utilized will be maintained per the manufacturer's instructions or physician's orders. respiratory treatments will be administered per current standards. unless otherwise ordered by a physician.</p>		

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<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>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure, in accordance with accepted professional standards and practices, medical records maintained for each resident were complete and accurately documented for 1 of 5 residents (Resident #1) reviewed for resident records. The facility failed to ensure CNA Z documented that incontinent care was provided for Resident #1 from 6:27 p.m. on 08/09/25 through 6:00 a.m. on 08/10/25. The facility failed to ensure LVN V documented on a nurse progress note on 08/10/25 when Resident #1 was crying in pain, level of pain, and required pain medication. These failures could place residents at risk for delayed care and appropriate interventions. Findings included: Record review of Resident #1's face sheet dated 08/11/25 indicated Resident #1 was a [AGE] year-old female, admitted on [DATE], and her diagnoses included left femur (thigh bone) fracture, muscle weakness, unsteadiness on feet, cellulitis (bacterial infection) of buttocks, cognitive communication deficit, and anxiety (intense, excessive and persistent worry and fear about everyday situations). Record review of Resident #1's admission assessment dated [DATE] indicated she was usually able to make herself understood and understood others, had moderately impaired cognition (BIMS-12), was dependent for toilet transfer, and was always incontinent of bladder and bowel. Record review of Resident #1's care plan dated 06/11/25 indicated she was always incontinent. Interventions included check and change if wet/soiled. Record review of Resident #1's care plan dated 06/11/25 indicated she was always incontinent of bowel movements. Interventions included check for incontinence and clean and dry if wet or soiled. Record review of Resident #1's incontinent care record dated 08/09/25 completed by CNA Z indicated Resident #1 was checked for incontinence of bladder and bowel on 08/09/25 at 6:27 p.m. The record indicated Resident #1 was incontinent. There was no documentation on Resident #1's incontinent care record after 6:27 p.m. Record review of Resident #1's MAR dated 08/10/25 at 1:14 a.m., completed by LVN V indicated she administered Tramadol (opioid used to treat pain) 25 mg tablet. Results were noted as effective at 2:14 a.m. Record review of a nurse progress note dated 08/10/25 at 8:23 a.m., completed by LVN Y indicated Resident #1 was sent out via 911 for evaluation and treatment for a fall at 7:10 a.m. Resident stable with no additional skin issues noted. There was no documentation of Resident #1 being incontinent, being in pain, or staff not being able to provide care. Record review of Resident #1's hospital records dated 08/10/25 indicated dried feces. During an interview on 08/11/25 at 9:43 a.m., RN X said Resident #1 arrived at the ER at approximately 8:07 a.m. on 08/10/25 with dried fecal matter contained to her brief. During an observation and interview on 08/11/25 at 10:57 a.m., Resident #1 was sitting in her wheelchair in the common area adjacent to the nurse's station. She was dressed in clean clothes. She said she was fine and had no complaints of her care. During an interview on 08/11/25 at 11:58 a.m., LVN Y said Resident #1 had feces in her brief when she was found on the floor on 08/10/25 at approximately 7:00 a.m. She said Resident #1 indicated she was in pain and not able to roll over for care. She said staff were not able to provide incontinent care prior to her transfer to the hospital. During an interview on 08/11/25 at 12:01 p.m., CNA W said she started her shift after 6:00 a.m. on 08/10/25. She said Resident #1 did not require incontinent care during her first round. She said she found Resident #1 on the floor at approximately 7:00 a.m. She said Resident #1 had a bowel movement but was in pain and was not able to roll for incontinent care prior to her transfer to the hospital. She said all care that was provided to residents should be documented in the electronic care record. During an interview on 08/11/25 at 12:46 p.m. the DON said there was no documentation of incontinent care for Resident #1 from 6:27 p.m. on 08/09/25 through 6:00 a.m. on 08/10/25. She said the CNAs and nurses were supposed to document the care because they did the hands-on care. She said it was her expectation staff would document care after the care was provided. She said residents were at risk for delayed care if the proper documentation was not completed. During an interview on 08/11/25 at 3:18 p.m., CNA Z said she completed rounds every two hours on 08/09/25 at 6:00 p.m. through 08/10/25. She said she completed incontinent care for Resident #1 at approximately 4:30 a.m. on 08/10/25. She said she did not document the care in Resident #1's care record. She said she was aware she should document care as it was completed. During an interview on 08/11/25 at 3:35 p.m., RN V said Resident #1 was crying and in pain after midnight on 08/10/25. She said she administered pain medication as ordered. She said she checked Resident #1 approximately 1.5 hours later and she was sleeping. She said she did not document Resident #1's status in the nurse progress notes. She said she was aware she should have documented in the nurse progress notes. She said</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to establish and 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 1 of 6 (Resident #3) residents reviewed for infection control. 1. CNA B failed to perform hand hygiene while performing incontinent care for Resident #3. These failures could place residents at risk for infection through cross contamination of pathogens. Findings included: 1. Record review of Resident #3's admission Record dated 08/11/25 reflected an [AGE] year-old female admitted to the facility on [DATE]. Diagnoses included Major Depressive Disorder, hypertension (high blood pressure), and constipation. Record review of Resident #3's Comprehensive MDS assessment dated [DATE] reflected her BIMS score was 99 (unable to complete the interview). The other fields of the MDS assessment were not yet filled out except for her diagnoses which included depression, a hip fracture, and hypertension (high blood pressure). Record review of Resident #3's Care Plan reviewed on 8/11/25 reflected it had no information or interventions related to infection control. During an observation and interview on 08/11/25 at 9:49 AM, Resident #3 was awake and lying in bed. CNA B and CNA C entered the room and did hand hygiene, closed the door, and closed the blinds. CNA B and CNA C put on gloves. CNA B lowered the resident's brief and cleaned her perineal area appropriately. CNA B removed her gloves and placed new gloves on without completing hand hygiene. CNA B and CNA C assisted Resident #3 to turn onto her side and CNA B cleaned her buttocks. CNA B rolled the dirty brief inward and threw it away. CNA B removed her gloves and placed new gloves on without completing hand hygiene. CNA B placed a clean brief, adjusted the resident, and covered her. CNA B and CNA C cleaned up the supplies and completed hand hygiene. During an interview with CNA B on 08/11/25 at 9:57AM, she stated she completed hand hygiene first. She stated she would do hand hygiene before, between, and after incontinent care. She stated she realized she had not done hand hygiene after incontinent care and glove changes, and she should have. She stated she was trained to complete hand hygiene after glove changes and when going from a dirty to clean brief. She stated the risk of not performing hand hygiene was that infection could spread. During an interview with LVN A on 08/11/25 at 12:57 PM, she stated hand hygiene should be completed before care, after the change (brief change) itself, and before leaving the room. She stated staff were trained on hand hygiene for infection control purposes. During an interview with the Director of Nursing on 08/11/25 at 1:25PM, she stated the expectation was for the facility staff providing incontinent care to perform hand hygiene before starting care, when changing gloves (such as when the gloves were dirty), and after care. The DON stated the ADON and herself were responsible for training about hand hygiene. The Director of Nursing stated not completing proper hand hygiene could cause cross contamination. Record review of a facility In-service Training Report, dated 07/09/25, reflected: CNA B and CNA C's signatures on the first page. The second page included, .Incontinent Care.7. Remove old brief and place in bag. Remove gloves, wash hands and reapply gloves.10. Remove gloves and place in bag. 11. Wash hands and apply new gloves. 12. Apply new brief or pad 13. Remove gloves and wash hands. Record review of the facility policy titled, Incontinence briefs and pad handling, long-term care dated 11/18/24, reflected .perform hand hygiene, put on gloves.remove and discard your gloves, perform hand hygiene, put on clean gloves.discard soiled brief.remove and discard your gloves.perform hand hygiene.</p>		