STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676109	A. Building B. Wing	10/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Calder Woods	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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide assistance devices and adequate supervision to prevent accidents for 1 of 3 residents (Resident #1) reviewed for accidents. The facility failed to ensure CNA A utilized a gait belt and had assistance from another staff member during a bed to wheelchair transfer on 11/19/24 which resulted in Resident #1 having a fall and complaints of pain. Resident #1 was sent to the local hospital emergency room where she was found to have fractured neck bones. She was care flighted to another hospital out of town for surgery to the neck. The noncompliance was identified as PNC. The Immediate Jeopardy (IJ) began on 11/19/24 and ended on 12/05/24. The facility had corrected the noncompliance before the investigation began.This failure could place residents at risk for falls resulting in injury, pain, hospitalization, and possible death. Findings included:Record review of a face sheet dated 05/19/25 indicated Resident #1 was an [AGE] year-old female admitted on [DATE]. Her diagnoses included kidney failure (condition where the kidney reaches advanced state of loss of function), gastrointestinal hemorrhage (bleeding from the small intestine or large intestine), gastroenteritis (inflammation that spreads from your stomach into your intestines), colitis (inflammation in the colon), pain, anemia (not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues), osteoarthritis (a degenerative joint condition that causes pain, stiffness, and inflammation), depression (mental illness that negatively affects how you feel, the way you think and how you act), hypertension (a condition in which the force of the blood against the artery walls is too high), and chronic obstructive pulmonary disease (a lung disease that blocks airflow making it difficult to breathe).Record review of a care plan initiated on 11/06/24 indicated Resident #1 required transfer assistance by 2 staff.Record review of the admission MDS dated [DATE] indicated Resident #1 cognitively intact with a BIMS of 15 out of 15. She was dependent (Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.) for chair/bed-to-chair transfers. She was 71 inches tall (5 foot 11 inches) and 229 pounds.Record review of Resident #1's progress notes indicated:* an entry dated 11/19/24 at 10:30 a.m. At 07:08 a.m. LVN B was notified of resident being on the floor by bedside by CNA A. Resident was noted on floor by the window on her left side. Resident said she fell face first (forward) laceration and redness noted on the bridge of her nose. Further assessment indicated a laceration to the left upper extremity. Resident was provided a pillow to rest head on to wait for EMS. EMS arrived around 07:15 a.m. Resident asked to get up complained of pain to the left upper extremity, right lower extremity, and crook in neck; and nausea. LVN B assist with board onto stretcher.* an entry dated 11/19/24 at 01:02 p.m. indicated LVN B was informed by Resident #1's RP resident was being transferred to another hospital due to neck fracture (C1-C2) from the fall this morning. LVN B also called the hospital emergency room and a diagnosis of neck fracture was given.Record review of the facility's investigation report dated 11/26/24 indicated on 11/19/24 Resident #1 had a fall and had initial signs of a laceration to her nose. Resident #1 was having significant pain and EMT's isolated her neck with a collar then transferred her by board to stretcher. The Administrator and DON interviewed CNA A. CNA A explained that she transferred Resident #1 from the bed to the chair, with one assist per plan of care. CNA A said Resident #1 leaned forward. CNA A was unable to stabilize the resident and she fell forward to floor. The investigation indicated that a gait belt was not in use at time of transfer. Resident #1 received a C-1 and C-2 fracture and will be required to wear a neck brace for a period of time. During an interview on 10/06/25 at 03:56 p.m. LVN B said she was coming on shift when the incident involving Resident #1 occurred. She said CNA A called and said she needed assistance to transfer Resident #1 so she and the night shift nurse went down to the room and Resident #1 was on the floor. She said CNA A said Resident #1 started falling and she tried to catch her. LVN B said Resident #1 had a cut on her nose. LVN B said Resident #1 complained of pain so EMS was contacted to send her to the hospital. LVN B said Resident #1 complained of pain to her neck when EMS arrived so they put a cervical collar on her. LVN B said she was contacted by Resident #1's family that she was being care flighted to another hospital due to a broken neck. She said Resident #1 usually was a 2-person transfer. She said a gait belt should always be used with 1 or 2 person transfers. During an interview on 10/06/25 at 04:32 p.m., the ED said CNA A was transferring Resident #1 without using the gait belt and a second staff on 11/19/24. She said Resident #1 fell forward hitting her face. She said the resident complained of pain and was sent to the local hospital emergency room. She said the family notified the facility the resident was being