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	11/06/2024

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33460 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate acquiring and administering of all drugs to meet the needs of the residents for 1 (Resident #139) of 13 residents reviewed for controlled medications. Resident #139's hydrocodone 5mg / acetaminophen 325 mg (narcotic pain medication for moderate or severe pain) 20 tablets were not accounted for at the time of discharge 09/11/24 and remained unaccounted for 55 days. This failure could place residents at risk for medication overdose, medication under-dose, ineffective therapeutic outcomes, and drug diversion. Findings : Record review of a face sheet dated 11/06/24 indicated Resident #139 admitted on [DATE] was [AGE] years old with diagnoses of fractured right hip and fractured right upper arm. The face sheet indicated discharged on [DATE] to another facility. The face sheet did not have contact information for the Resident #139. There was contact information for her family (her son) . Record review of physician orders dated September 2024 indicated Resident #139 orders included hydrocodone 5 mg/ acetaminophen 325 mg as needed for pain with start date of 08/22/24. Record review of the MAR dated September 2024 indicated Resident #139 received a hydrocodone 5 mg/ acetaminophen 325mg by mouth on 09/01/24, 09/04/24 and 09/07/24. Record review of the annual MDS assessment dated [DATE] for Resident #139 was cognitively intact. She had fractures and received an opioid (pain medication) during the last 7 days. Record review of the care plan dated 09/02/24 indicated Resident #139 had pain related to her fractured right leg and right arm. Intervention included she would receive medications per physician's orders. Record review of physician orders dated September 2024 indicated Resident #139 orders included hydrocodone 5 mg/ acetaminophen 325 mg as needed for pain with start date of 08/22/24. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the MAR dated September 2024 indicated Resident #139 received a hydrocodone 5 mg/ acetaminophen 325mg by mouth on 09/01/24, 09/04/24 and 09/07/24. During an observation and interview on 11/5/24 at 9:50 a.m., the interim DON A opened the cabinet and said the cabinet was in his office and was used to store narcotics for destruction. He said this was the first time he had opened this cabinet. The cabinet was secured with 2 locks and was empty. He pointed at the logbook and said when a narcotic was placed in the cabinet, staff logged in the medication. The logbook contained a stack of blank logs and there was an undated log form that had 2 narcotic medications listed on the form. The interim DON A said he had not seen that page before and said he would find out where the narcotics were atheld. He said there was another interim DON B before he was hired last week, and she might know where those narcotics were at. Record review of the undated log record indicated there should have been 2 cards or bottles containing 20 narcotics each. The log indicated date dispensed on: *08/22/24 RX#2028970, hydrocodone (norco) 20 tablets and *09/06/24 RX # 2041187- 20 tablets of Xanax 0.5mg (antianxiety narcotic). During an interview on 11/05/24 at 10:30 a.m., the interim DON B said she was a corporate regional RN, and she had been the acting interim DON after the last DON was terminated. She said she had not opened the narcotic cabinet while she was the interim DON at this facility. She said she had not been given any narcotics for destruction and had not destroyed any narcotics. She said any narcotics not released to residents or family upon discharge or narcotics which had been discontinued, would be given to the DON. The interim DON B said the narcotics would be logged in and placed in the double locked cabinet and would be destroyed with DON, a nurse or administrator and the pharmacist. During an interview on 11/05/24 at 12:30 p.m., the interim Administrator said his expectation was for the narcotics to be kept in a secured manner per the facility policy and they were looking for the 2 narcotics prescriptions that were misplaced or missing. He said they had reached out to the pharmacy to identify who the residents were, and they were interviewing the staff who had discharged the residents who the narcotics was prescribed to. Attempted an interview on 11/05/24 at 2:30 p.m., No answer Resident #139's family phone. A detailed message with the surveyor's contact information was left on the answering machine. During an interview on 11/05/24 at 3:30 p.m. the interim DON A said they had located some narcotics which had been placed in a treatment cart and should not have been stored there. He said one of the missing medication was located. He said the 20 tablets of the prescription of hydrocodone 5mg/325 mg for Resident #139 had not been located. He said they were still investigating and had a call out to the family for Resident #139 who had been discharged on [DATE] to a local rehabilitation hospital. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/06/24 at 9:30 a.m., the case manager of the rehabilitation hospital where Resident #139 was discharged said the facility had called yesterday evening about this medication and this hospital did not receive the hydrocodone for Resident #139. She said the physician here had ordered Resident #139 hydrocodone 7.5mg/325 mg during her stay here. The case manager said Resident #139 had not required any pain medication during her stay there and had since been discharged home. She said no narcotics were received. If they had been received the pharmacy would have logged the medication into our system. During an interview on 11/06/24 at 10:00 a.m., LVN C said she was in orientation when Resident #139 discharged on [DATE]. She said normally if the medications were sent with the resident, she would normally print a list of meds and write down how many were sent home. She said she did not remember the discharge for Resident #139. She said she might have sent a list with the resident and did not make a copy. She said she did not remember anything about the resident or the discharge. She said during her orientation the ADON was here. During an interview on 11/06/24 at 10:15 a.m., the ADON said she did not remember a lot about the discharge for Resident #139 however she said the previous DON had told her not to send medications when residents went to the rehab hospital. She said she never saw Resident #139's medications during the discharge on 09/11/24 or after that day. During an interview on 11/06/24 at 10:20 a.m. the interim Administrator said they could not locate the narcotic for Resident #139 and the facility reported the incident of the missing medication to the state and local police. He said the family of Resident #139 had never returned his call. He said, We must have an issue with the drugs being stored for destruction. During an interview on 11/06/24 at 1:00 p.m., the interim DON A said his expectation for the narcotics were to be turned into the DON or interim DON and he was training all the nurses on the new policy. He said they did not have a policy and procedure prior to the DON receiving the narcotics for destruction. Record review of the policy dated 11/05/24 titled Narcotics indicated . All active and discontinued Narcotic meds will be left on the cart and counted each shift until the DON is available to receive or take off the cart. When a resident is discharged with narcotics 2 nurses and the family or who is receiving the narcotics has to sign the narcotic count sheet and note the number given and the sheet placed in the scanning bin.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36214 Based on observation, interview 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 1 of 13 residents (Resident #136) reviewed for infection control. LVN C failed to wear a gown during wound care for Resident #136 who was on Enhanced Barrier Precautions (EBP). This failure could place residents at risk of exposure to communicable diseases and infections. Findings included: Record review of Resident #136's face sheet dated 11/06/24 indicated she was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included elevated white blood cell count (when the body produces more white blood cells than normal which could be caused by infection) and stage 3 (a deep wound that extends through the skin and into the subcutaneous tissue) pressure ulcer (a localized injury to the skin and soft tissue that occurs when an area of skin is under sustained pressure). Record review of an admission MDS dated [DATE] indicated Resident #136 had moderately impaired cognition. The MDS had not been completed and had no further information. Record review of a care plan dated 11/05/24 indicated Resident #136 had a stage 3 ulcer to her sacrum and staff were to utilize EBP which included wear gloves and gown during wound care of any skin opening requiring a dressing. During an observation on 11/04/24 at 9:45 a.m., Resident #136's door had a sign instructing she was on EBP and a supply cart containing needed PPE (a type of clothing or equipment that protects people from injury or illness in the workplace). During an observation on 11/05/24 at 3:25 p.m., LVN C prepped her supplies on a sterilized bedside table in Resident #136's room. She washed her hands and put on gloves. She then returned to the bedside and unfastened Resident #136's brief, rolled her to her right side and removed a dressing from her sacral wound. She washed her hands and put on clean gloves. She cleansed the wound using wound cleanser and gauzed, patted the area dry with gauze, applied collagen powder mixed with an antimicrobial skin wound gel, and covered with a border dressing. LVN removed her gloves, washed her hands and exited the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/05/24 at 3:57 p.m., LVN C said she forgot to put on a gown while doing wound care for Resident #136. She said she realized she had not worn the gown when she finished the wound care. She said she had been in a hurry because she had so much that she needed to get done. LVN C said a gown and gloves were always required when doing wound care or having direct contact with a resident on EBP and Resident #136 was on EBP due to having an open wound. She said not wearing a gown when giving care to a resident on EBP could result in cross contamination to other residents. She said she was given training on EBP during her orientation a few months ago. During an interview on 11/05/24 at 4:02 p.m., the interim DON said his expectation was for all nursing staff to glove and gown when giving care requiring direct contact with a resident on EBP. He said all nursing staff had been trained on the requirements of EBP. He said not wearing appropriate PPE during direct contact care to a resident on EBP could cause cross contamination to other residents and staff. During an interview on 11/06/24 at 1:15 p.m., the interim Administrator said he expected all staff to follow CMS guidelines for EBP including donning and doffing appropriate PPE and hand hygiene. He said the interim DON was ultimately responsible for monitoring EBP, but all department heads made rounds daily and had been trained on EBP. He said a possible negative outcome of not following the guidelines for EBP could be the transfer of disease or illness to other residents and staff. Record review of a facility policy titled Isolation Categories of Transmission-Based Precautions and Enhanced Barrier Precautions revised 10/23/24 indicated, . Enhanced barrier precautions expand the use of PPE beyond situations in which exposure to blood and body fluids is anticipated and refer to the use of gown and gloves during high-contact resident care areas that provide opportunities for transfer of multidrug-resistant organisms (MDROs) to staff hands and clothing. Examples of high contact resident care activities requiring gown and glove use for enhanced barrier precautions include: . Wound care: any skin opening requiring a dressing.