

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455944	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2026
NAME OF PROVIDER OR SUPPLIER Focused Care at Clarksville		STREET ADDRESS, CITY, STATE, ZIP CODE 2407 West Main Street Clarksville, TX 75426	
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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents assessments accurately reflected the resident's status for 3 of 15 residents (Residents #7, #8 and #36) reviewed for accuracy of assessments. 1. The facility failed to accurately complete the MDS assessment to indicate Resident #7's PASRR status was positive. 2. The facility failed to accurately complete the MDS assessment to indicate Resident #8's tobacco use.3. The facility failed to accurately complete the MDS assessment to indicate Resident #36's PASRR status was positive. These failures could place residents at risk of not receiving the appropriate care and services to maintain their highest level of well-being. Findings included: 1. Record review of Resident #7's face sheet, dated 02/24/2026, indicated a [AGE] year-old male, admitted [DATE] and readmitted [DATE]. Resident #7 had diagnoses which included anxiety and major depressive disorder. Record review of Resident #7's physician orders, dated 02/2026, indicated diagnoses of major depressive disorder and anxiety. Record review of Resident #7's significant change MDS assessment, dated 10/14/2025, indicated Resident #7 was not marked for current PASRR positive during the assessment period. The assessment indicated Resident #7 had a BIMS score of 15, which indicated intact cognition. Record review of Resident #7's care plan, with a target date of 03/22/2026, indicated Resident #7 was PASRR positive status for mental illness related to anxiety and depression requiring a recent psychiatric inpatient stay. Record review of an undated list of PASRR positive residents provided by the facility indicated Resident #7 was PASRR positive and refused services. 2. Record review of Resident #8's face sheet, dated 02/23/2026, indicated a [AGE] year-old female, admitted [DATE] and readmitted [DATE]. Resident #8 had a diagnosis which included chronic obstructive pulmonary disease (group of lung diseases that block airflow and make it difficult to breathe). Record review of Resident #8's annual MDS assessment, dated 04/29/2025, indicated Resident #8 was not marked for current tobacco use during the assessment period. The assessment indicated Resident #8 had a BIMS score of 12, which indicated moderately impaired cognition with a diagnosis of chronic obstructive pulmonary disease. Record review of Resident #8's care plan, with a target date of 03/22/2026, indicated Resident #8 (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was a smoker with interventions that included facility staff would keep all lighters and resident would participate in supervised smoking breaks. Record review of a Safe Smoking Assessment, dated 04/28/2025, indicated Resident #8 required direct supervision while smoking and all smoking materials be kept at the nurse's station. During an observation and interview on 02/23/2026 at 9:45 a.m., Resident #8 was sitting on her bedside. Resident #8 said she smoked daily; the staff kept her smoking supplies and monitored her during smoking times. Resident #8 said she was aware of the smoking times. During an observation and interview on 02/24/2026 at 1:11 p.m., Resident #8 was observed smoking, a staff member was observed lighting the cigarette and provided smoking supplies and monitored the resident during the smoking episode. Resident #8 said she smoked daily and had smoked daily since her admission to the facility but may try to quit soon. During an interview on 02/25/2026 at 10:05 a.m., LVN A said she was providing care for Resident #8 today and she smoked cigarettes daily. LVN A said the staff kept Resident #8's smoking supplies, lit her cigarettes and monitored her during smoking episodes. She said the MDS Nurse was responsible for all MDSs in the facility. 3. Record review of a face sheet dated 02/24/26 indicated Resident #36 was a [AGE] year-old male admitted on [DATE]. His diagnoses included schizophrenia (a mental disorder characterized variously by hallucinations (typically, hearing voices), delusions, disorganized thinking and behavior, and flat or inappropriate affect), schizoaffective disorder (mental health condition with a combination of symptoms of schizophrenia and mood disorder), psychotic disorder (a severe mental condition in which thoughts and emotions are so affected that contact is lost with external reality) with hallucinations (belief or altered reality that is persistently held despite evidence or agreement to the contrary), and bipolar disorder (mental disorder associated with episodes of mood swings ranging from depressive lows to manic highs). Record review of a PASRR Level 1 Screening dated 08/19/25 indicated Resident #36 was discharged from a psychiatric hospital. The form was marked no for dementia as a primary diagnosis and yes for Mental Illness. Record review of a LMHA letter dated 08/20/25 indicated Resident #36 did meet criteria for mental illness and qualified for special services. Record review of an annual MDS assessment dated [DATE] for Resident #36 indicated for A1500: Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? was marked no. During an observation and interview on 02/23/26 at Resident#36 was in bed watching TV. He said he's had a headache since he bruised his brain in 1976 and medications don't really help. He said he had no issues with his care. During an interview on 02/24/26 at 02:11 p.m. the DON said she was not real familiar with PASRR or MDS. She said she was not aware of what needed to be done if the MDS was incorrect when Resident #36's PASRR indicated he was positive and did meet criteria. She said she thought the MDS should reflect he was PASRR positive even though he refused services. (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a phone interview and record review on 02/25/2026 at 10:55 a.m., the MDS Nurse said she was responsible for all MDSs completed in the facility and her back up that double checked random MDSs was the Clinical Reimbursement Nurse. She said the Clinical Reimbursement Nurse was not available for interview. The MDS Nurse said she was educated on the completion of MDSs. She said Resident #8's MDS, dated [DATE], was not completed by her but it should have been marked for smoking. She said Resident #8 smoked according to the Smoking Assessment on 4/28/25. She said it was overlooked at the annual MDS. The MDS Nurse said the resident's risk of an MDS not marked correctly was it could affect the residents care and needs and the resident's care plan. The MDS Nurse said Resident #7's MDS assessment dated [DATE] should have been coded positive for PASRR and they completed a modification after surveyor intervention. During an interview on 02/25/2026 at 10:45 a.m., the DON said the MDS Nurse was responsible for all MDS in the facility with the Clinical Reimbursement was the backup that double checked random MDSs. She said the MDS Nurse was educated on the completion of MDSs. The DON said the MDSs marked incorrectly were overlooked. She said she expected all MDSs in the facility to be correct and accurate. The DON said the resident risk of an MDS marked incorrectly was the MDS may not paint a good picture of residents and the care the residents needed. During an interview on 02/25/2026 at 11:00 a.m., the Administrator said the MDS Nurse was responsible for all MDSs in the facility and was educated on the completion of MDSs. She said the Clinical Reimbursement was the backup to double check some MDSs for accuracy. The Administrator said the resident risk of an MDS not marked correctly was the MDS may not paint a good picture of the resident and resident's care. She said her expectation was all MDSs be correct and accurate. Record review of the facility's policy titled, Resident Assessment, revised 11/15/2023, indicated, . The purpose of this policy is to ensure accuracy and timeliness of MDS completion. 1. Each facility must follow most updated MDS RAI rules and regulations for completing each MDS accurately and timely. Record review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated October 2023, indicated .A1500: Preadmission Screening and Resident Review (PASRR). Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness and/or ID/DD or related condition, and continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions. .J1300: Current Tobacco Use coding . Steps for Assessment 1. Ask the resident if they used tobacco in any form during the 7-day look-back period. 2. If the resident states that they used tobacco in some form during the 7-day look-back period, code 1. Yes. Coding Instructions, Code, no: if there are no indications that the resident used any form of tobacco. Code 1, yes: if the resident or any other source indicates that the resident used tobacco in some form during the look-back period Record review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated October 2023, indicated .Guidelines for Determining When a Significant Change Should Result in Referral for a Preadmission Screening and Resident Review (PASRR) Level II Evaluation: If an SCSA occurs for an individual known or suspected to have a mental illness, intellectual disability, or related condition (as defined by 42 CFR 483.102), a referral to the State Mental Health or Intellectual Disability/Developmental Disabilities Administration authority (SMH/ID/DDA) for a possible Level II PASRR evaluation must promptly occur as required by Section 1919(e)(7)(B)(iii) of the Social Security Act.5		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 1 medication rooms and 1 of 2 medication carts for 4 of 18 residents reviewed for pharmacy services (Resident #8, #42, #43 and #52). 1. The facility failed to perform an inventory of controlled substances of the medication cart upon transfer of keys between staff. 2. The facility failed to ensure expired medications were removed from all medication carts and medication rooms. These failures could place residents at increase risks of drug diversion and of receiving medications that were not at their intended potency and potential adverse reactions or side effects. 1. During an observation on 02/23/2026 at 09:05 a.m., MA B was observed rolling the medication cart into the medication room. MA B then informed LVN A she had a family emergency and needed to leave work. MA B handed her medication cart keys to LVN A and exited the facility. During an observation and interview on 02/23/2026 at 09:15 a.m., LVN A exited the medication room with a medication cart. She said the cart was the one that MA B was working on. LVN A said she received the keys from MA B and said the narcotics on the cart were not counted prior to MA B leaving. She said she knew they should have counted the narcotics between themselves, and due to the emergency, they failed to do so. During an interview on 02/23/2026 at 10:45 a.m., the DON said LVN A and MA B should have counted the narcotics prior to MA B leaving the facility. She said her expectations were for narcotics to be counted at every shift change and at any change of hands in between. She said staff were educated on counting narcotics in these situations. The DON said drug diversions and missing medications were potential negative outcomes for failure to count narcotics. During an interview on 02/24/2026 at 12:15 p.m., the administrator said anytime the medication carts changed between shifts or in emergency situations, the narcotics should be counted between staff who were responsible for the carts. She said failure to count narcotics on the carts could potentially result in drug diversion or missing medications. During an interview on 02/24/2026 at 2:20 p.m., MA B said she had a family emergency regarding her child and had to leave work. She said she handed the keys to her medication cart to LVN A prior to exiting the facility. MA B said she was trained to always count narcotics when taking control of the medication cart and when handing it off to the next shift, as well as during unusual circumstances. MA B said she was aware her responsibility was to have counted with LVN A prior to leaving the facility and she had failed to do so. MA B said potential risks were drug diversion and residents not receiving medications timely. 2. Record review of Resident #8's face sheet, dated 02/23/2026, indicated a [AGE] year-old female, admitted [DATE] and readmitted [DATE]. Resident #8 had a diagnosis which included chronic obstructive pulmonary disease (group of lung diseases that block airflow and make it difficult to breathe). Record review of Resident #8's annual MDS assessment, dated 04/29/2025, indicated Resident #8 (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was not marked for current tobacco use during the assessment period. The assessment indicated Resident #8 had a BIMS score of 12, which indicated moderately impaired cognition with a diagnosis of chronic obstructive pulmonary disease. Record review of Resident #8's care plan, with a target date of 03/22/2026, indicated Resident #8 was a smoker with interventions that included facility staff will keep all lighters and resident will participate in supervised smoking breaks. Record review of Resident #42's face sheet, dated 02/25/2026, indicated a [AGE] year-old female, admitted [DATE]. Resident #42 had diagnoses which included hypertension (high blood pressure) and heart failure (condition where the heart cannot pump enough blood and oxygen to support the body's needs.) Record review of Resident #42's quarterly MDS assessment, dated 12/05/2025, indicated Resident #42 had a BIMS score of 8, which indicated moderately impaired cognition with a diagnosis of hypertension and heart failure. Record review of Resident #42's care plan, with a target date of 04/02/2026, indicated Resident #42 was at risk of cardiac failure and heart failure and hypertension with interventions that included received medication as ordered. Record review of Resident #42's physician orders, dated 02/25/2026, indicated she was prescribed amlodipine 5 mg every day with a start date of 12/03/2023. Record review of Resident #43's face sheet, dated 02/25/2026, indicated an [AGE] year-old female, admitted [DATE]. Resident #43 had a diagnosis which included hypertension (high blood pressure) Record review of Resident #43's quarterly MDS assessment, dated 01/28/2026, indicated Resident #43 had a BIMS score of 3, which indicated severely impaired cognition with a diagnosis of hypertension. Record review of Resident #43's care plan, with a target date of 04/02/2026, indicated Resident #43 had a diagnosis of hypertension and interventions that included received medication as ordered. Record review of Resident #43's physician orders, dated 02/25/2026, indicated she was prescribed Diltiazem HCL 180 mg every day for hypertension with a start date of 03/18/2023. Record review of Resident #52's face sheet, dated 02/25/2026, indicated an [AGE] year-old female admitted [DATE]. Resident #52 had a diagnosis which included depression (a mood disorder characterized by persistent sadness, low energy and loss of interest in activities). Record review of Resident #52's admission MDS assessment, dated 01/28/2026, indicated Resident #52 had a BIMS score of 10, which indicated moderately impaired cognition with a diagnosis of depression. Record review of Resident #52's care plan, with a target date of 04/30/2026, indicated Resident #52 had a diagnosis of depression and interventions that included received medication as ordered. Record review of Resident #52's physician orders, dated 02/25/2026, indicated she was prescribed (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Venlafaxine HCL ER 180 mg every day for depression with a start date of 01/20/2025. During an observation and interview on 02/25/2026 at 8:58 a.m., Hall 400, 500, 600 MA cart with LVN C revealed 1 medication card with 15 of 30 pills (1/2 light blue/1/2 dark blue capsules) diltiazem CL 180 mg every day for blood pressure with a use by date of 12/24/2025 labeled for Resident #43. Also discovered was 1 medication card with 30 of 30 pills amlodipine 5 mg every day with a use by date of 05/02/2025 labeled for Resident #42. LVN C said the nurses and MA that gave medication off this medication cart were responsible for ensuring all expired medications were removed from the medication cart and placed in the medication destruction bin. She said she was giving medication off this medication cart today and was educated on removal of expired medication. LVN C said the DON was the backup that made random checks for expired medication on the medication carts. She said these expired medications were overlooked. LVN C said the resident risk of expired medication left on a medication cart was they may have decreased potency. She said she had not given any of the expired medication. During an observation and interview on 02/25/2026 at 9:40 a.m., the facility medication storage room with LVN D was discovered 1 full bottle and one bottle with 1/10 the ingredients of Guardian brand 13 oz Fiber powder both with an expiration date of January 2026. In a cubby labeled Resident #8 was discovered one box of Nicotine transdermal system patch (to help stop smoking) 14 mg delivered over 24 hours, 12 of 14 patches with an expiration date of April 2025 that was labeled Resident #8. In a cubby labeled for Resident #52 was 1 bottle of one a day vitamin with minerals 2/4 full of 60 tablets opened and with an expiration date of 11/2025 and 1 bottle of Venlafaxine HCL ER (antidepressant medication) 150 mg labeled to give 1 capsule per day for Resident #52 with an expiration date of 9/2025. The bottle included 14 of 90 pills. LVN D said all the nurses and MAs were responsible for ensuring all expired medication were removed from the medication room and stored in the medication destruction bin. She said the pharmacy consultant was a backup that double checked the medication room for expired medication monthly. She said the expired medications were overlooked. LVN D said all the nurses and MAs were educated on removal of expired medication from the medication room. She said the resident risk of expired medication not removed from the medication room was the medication could be used and be less effective as it should be. LVN D said the expired medications should have been removed from the medication room and disposed of in the medication destruction bin. During an interview on 02/25/2026 at 10:00 a.m., the DON said the nurses and MAs were all responsible and educated on ensuring all expired medication was removed from medication carts and the medication room and placed in the medication destruction bin. She said she was the back up to double check medication carts and the medication room for expired medication and did random checks monthly. She said the Pharmacy Consultant also did random checks monthly for the medication carts and medication room. She said the expired medications found were overlooked. The DON said the potential resident risk of expired medication not removed from the medication carts or medication room was they may not be as effective as should be. She said her expectation was the nurses and MAs checked and removed all expired medication from the medication carts and medication room and placed in the medication destruction bin. During an interview on 02/25/2026 at 10:15 a.m., the Administrator said the nurses and MA were all responsible and educated on ensuring expired medication was removed from the medication carts and the medication room and placed in the medication destruction bin. She said the DON was the back up to double check medication carts and the medication room for expired medication through random checks monthly. The Administrator said the expired medications were overlooked. She said the (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	potential resident risk of expired medication not removed from the medication carts or medication room was the expired medication could be used and may not be as effective as should be. The Administrator said her expectation was staff remove all expired medication from the medication carts and medication room and placed in the medication destruction bin. During an interview on 02/25/2026 at 11:50 a.m., the Pharmacy Consultant said she did random checks monthly of a medication cart or the medication room and the Pharmacy Technician checked all the medication carts and medication room monthly for expired medications and then quarterly when the facility was not in their survey window. She said the expired medications were overlooked. The Pharmacy Consultant said the Pharmacy Technician should have pulled the expired medication from the medication carts and medication room for destruction. The Pharmacy Consultant said the resident risk of expired medication on the medication carts and in the medication room was the medications could be administered and not be as effective. During an attempted interview on 02/25/2026 at 12:15 p.m., the Pharmacy Technician message was left to return call with no response. Record review of the Monthly Consultant Pharmacist Report, dated 02/13/2026, indicated, .Medication Cart for Halls 100, 200, 300 was reviewed expired medication was removed with no medication labeling or dating concerns . Record review of a facility policy, revised 08/2020, titled, Preventing and Detecting Adverse Consequences and Medication Errors, indicated, . d. Checking the medication storage areas and the medication carts for proper storage and labeling of medications, cleanliness, and removal of expired medications. 7. No expired medication will be administered to a resident. 8. All expired medications will be removed from the active supply and destroyed in accordance with facility policy, regardless of amount remaining. In order to safeguard the quality and stability of medications used within the facility, medications brought to the facility by other than the designated pharmacist or agent can be accepted only if there is a current order for use, the medication is in a proper container properly labeled, the medication has not expired, and the medication has been positively identified by the physician or pharmacist prior to use. The facility will have documentation that the identification has been made. Review of the Policy and Procedures - Pharmacy Services for Nursing Facilities, dated 08/2020, indicated the following.Policy: Medications classified by the Drug Enforcement Administration (DEA) as controlled substances are subject to special handling, storage, disposal, and recordkeeping in the facility in accordance with federal, state, and other applicable laws and regulations. Procedures: 5. Unless otherwise indicated in a facility policy and/or as required by state regulations, the following will be performed: a) at each shift change, or when keys are transferred, a physical inventory of all controlled substances, including refrigerated items, is conducted by two licensed personnel and is documented.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, 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 2 of 2 residents observed for incontinent care (Residents #5 and #32), for 1 of 1 resident observed for wound care (Resident #5), and 1 of 1 resident for transfers (Resident #32). * CNA F and CNA G used gloves pulled from their pockets, CNA G touched clean items without hand hygiene between glove changes, CNA F did not do hand hygiene between glove changes, and CNA G did not wash her hands before leaving the room when they provided incontinent care and Hoyer lift transfer on Resident #32. * CNA F used gloves pulled from her pocket, LVN C used gloves pulled from CNA F's pocket, and when cleaning the wound LVN C did not do hand hygiene between glove changes when they provided incontinent care and wound care to Resident #5. These failures could place residents at risk for spread of infections or worsened infections. Findings included: 1. Record review of a face sheet dated 02/25/26 indicated Resident #32 was a [AGE] year-old female readmitted on [DATE]. Her diagnoses included kidney failure (condition where the kidney reaches advanced state of loss of function). Record review of the quarterly MDS dated [DATE] indicated Resident #32 was cognitively intact with a BIMS of 14 out of 15. She was dependent on assistance with toileting. During an observation and interview on 02/23/2026 at 09:55 a.m. of incontinent care provided to Resident #32 by CNA F and CNA G. CNA F and CNA G had gloves in their pockets. After removing the dirty brief with feces, CNA G changed gloves with no hand hygiene between. A clean brief was placed and Resident #32 was transferred by Hoyer lift to wheelchair with CNA G not performing hand hygiene between glove changes. CNA F and CNA G were asked if they would have or should have done anything different and they said no. CNA G left Resident #32's room without washing her hands. During an interview on 02/24/26 at 10:12 a.m. CNA F was asked about the incontinent care provided to Resident #32 on 02/23/26 and she said they should have changed gloves with hand hygiene between. She said the hand washing she did after changing the dirty brief CNA G should have also done. She said staff should always wash their hands when entering and exiting a resident room. 2. Record review of a face sheet dated 02/25/26 indicated Resident #5 was a [AGE] year-old male readmitted on [DATE]. His diagnoses included malignant neoplasm (uncontrolled growth of cells) of the prostate (a gland in the male reproductive system) and paraplegia (injury to the spinal cord or brain that stops signals from reaching the lower body). Record review of the February 2026 physician orders for Resident #5 indicated he had an order dated 06/21/25 for Enhanced Barrier Precautions due to wound care requirements and indwelling device every shift Record review of the quarterly MDS dated [DATE] indicated Resident #5 had intact cognition with a BIMS of 13 out of 15. He required substantial/maximum assistance with toileting. He had an indwelling urinary catheter and was frequently incontinent of bowel. He had an unhealed stage 4 pressure ulcer. Record review of a care plan revised 02/23/36 indicated Resident #5 required substantial/maximum assistance with toileting, had an indwelling urinary catheter, was incontinent of bowel, had an unhealed stage 4 pressure ulcer, and was EBP due to catheter and wound. During an observation and interview on 02/24/2026 at 10:00 a.m. of incontinent care and wound care provided to Resident #5 by LVN C and CNA F. While providing incontinent care, CNA F pulled gloves from her pocket when changing gloves during incontinent care on the front of Resident #5. LVN C ran out of gloves during wound care and CNA F gave gloves from her pocket to LVN C to complete wound care. While cleaning the wound to the sacral area, LVN C utilized the gloves given to her by CNA F from her pocket and did not do hand hygiene between glove changes. CNA F said she thought she could put the gloves in her pocket. LVN C said she thought she used sanitizer between all of the glove changes. She said she did not realize she did not during a few of the changes. She said she ran out of gloves she had for wound care while assisting with (continued on next page)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455944	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2026
NAME OF PROVIDER OR SUPPLIER Focused Care at Clarksville		STREET ADDRESS, CITY, STATE, ZIP CODE 2407 West Main Street Clarksville, TX 75426	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	incontinent care and did not think about the gloves being pulled out of CNA F's pocket. During an interview on 02/25/2026 at 10:20 a.m. the DON indicated staff should place gloves in a plastic bag to provide care to residents. She said she expected staff to wash their hands after cleaning a resident with a bowel movement and when they enter/exit a resident room. She said staff should always do hand hygiene between glove changes. She said they could spread infections to the residents or to other residents. During an interview on 02/25/2026 at 11:00 a.m., the Administrator said she expected staff to follow the policies on hand hygiene and glove use. Record review of a Hand Hygiene policy revised 10/24/22 indicated Policy:.1. You should always perform hand hygiene:.Before applying and after removing personal protective equipment (e.g. gloves, gown, mask, face shield/goggles), Before and after providing any type of care.2. You must perform hand hygiene (hand washing or the use of ABHR) after contact with bodily fluids, such as urine or blood, mucous membranes, such as the mouth or nose, and non-intact skin.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 20 residents (Resident #36) reviewed for care plans. The facility failed to ensure that Resident #36's care plan addressed his PASRR positive status. This failure could place residents at risk of not receiving appropriate interventions to meet their current needs. Findings included: Record review of a face sheet dated 02/24/26 indicated Resident #36 was a [AGE] year-old male admitted on [DATE]. His diagnoses included schizophrenia (a mental disorder characterized variously by hallucinations (typically, hearing voices), delusions, disorganized thinking and behavior, and flat or inappropriate affect), schizoaffective disorder (mental health condition with a combination of symptoms of schizophrenia and mood disorder), psychotic disorder (a severe mental condition in which thoughts and emotions are so affected that contact is lost with external reality) with hallucinations (belief or altered reality that is persistently held despite evidence or agreement to the contrary), and bipolar disorder (mental disorder associated with episodes of mood swings ranging from depressive lows to manic highs). Record review of a PASRR Level 1 Screening dated 08/19/25 indicated Resident #36 was discharged from a psychiatric hospital. The form was marked no for dementia as a primary diagnosis and yes for Mental Illness. Record review of a LMHA letter dated 08/20/25 indicated Resident #36 did meet criteria for mental illness and qualified for special services. Record review of the care plan revised 01/09/26 indicated Resident #36 had no care plan to address his PASRR positive status. During an observation and interview on 02/23/26 at Resident #36 was in bed watching TV. He said he's had a headache since he bruised his brain in 1976 and medications don't really help. He said he had no issues with his care. During an interview on 02/24/2026 at 02:11 p.m. the DON said she was familiarizing herself with care plans. She said Resident #36 should have a care plan indicating he was PASRR positive even though he refused services. During a phone interview and record review on 02/25/2026 at 10:55 a.m., the MDS Nurse said she was responsible for care plans completed in the facility. The MDS Nurse said she was educated on completion of care plans. She said Resident #36's care plan should have addressed his PASRR positive status. The MDS Nurse said the resident risk of an MDS not marked correctly was that it could affect the residents care and needs and the resident's care plan. During an interview on 02/25/2026 at 10:45 a.m., the DON said the MDS Nurse was responsible for all care plans in the facility. She said the MDS Nurse was educated on the completion of care plans. The DON said the resident risk of a care plan not addressing a resident's status may not paint a good picture of residents and the care the residents needed. During an Interview on 02/25/2026 at 11:00 a.m., the Administrator said the MDS Nurse was responsible for all care plans in the facility and was educated on completion of care plans. The Administrator said the resident risk of a care plan address all the resident needs may not paint a good picture of resident and resident's care. She said her expectation was all care plans be correct and accurate. Record review of a Comprehensive Care Plan Policy revised 04/25/21 indicated POLICY: Every resident will have an individualized interdisciplinary plan of care in place. A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of Admission. The Interdisciplinary Team will continue to develop the plan in conjunction with the RAI (MDS 3.0) and CAAS, completing and conducting Comprehensive Care Plan Meeting and Reviews by day 21 after Admission. The Care Plan is revised every quarter, significant change of condition, Annual or as the resident condition changes on an individualized basis. The Care Plan process is an ongoing review process. The resident's Care Plan will include participation from (continued on next page)		

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents' representatives, external partners PASRR, Hospice, Therapy, Clinicians and not as all-inclusive.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident's drug regimen was free from unnecessary medications (is a medication used: for excessive duration) for 2 of 5 residents (Residents #5 and #32) reviewed for unnecessary medications. * The facility did not have a stop date for Resident #5's Methenamine Hippurate (antibiotic) * The facility did not have a stop date for Resident #32's Bactrim DS (antibiotic) These failures could place residents at risk for antibiotic resistance infections due to excessive use of antibiotics. Findings included:1. Record review of a face sheet dated 02/25/26 indicated Resident #5 was a [AGE] year-old male readmitted on [DATE]. His diagnoses included malignant neoplasm (uncontrolled growth of cells) of the prostate (a gland in the male reproductive system) and paraplegia (injury to the spinal cord or brain that stops signals from reaching the lower body). Record review of February 2026 physician orders for Resident #5 indicated he had an order dated 12/26/25 to receive Methenamine Hippurate Oral Tablet 1 GM 1 tablet by mouth two times a day for urinary antiseptics. There was no stop date on the order. Record review of a Physician Progress Notes dated 01/29/26 for Resident #5 indicated there was no documentation as for the reason for no stop date on the order. 2. Record review of a face sheet dated 02/25/26 indicated Resident #32 was a [AGE] year-old female readmitted on [DATE]. Her diagnoses included kidney failure (condition where the kidney reaches advanced state of loss of function). Record review of February 2026 physician orders for Resident #32 indicated she had an order dated 01/28/2026 to receive Bactrim DS Oral Tablet 800-160 mg (Sulfamethoxazole-Trimethoprim) 1 tablet by mouth one time a day for chronic UTIs. There was no stop date on the order. Record review of a Physician Progress Note dated 01/29/26 for Resident #32 indicated there was no documentation as for the reason for no stop date on the order. During an interview on 02/25/2026 at 09:05 a.m. IP indicated she thought the physician had ordered the antibiotic prophylactically (to prevent infection) for UTI. She indicated she did not see any notes from the physician about the antibiotic. She indicated she would reach out to request any documentation they may have. During an interview on 02/25/2026 at 10:20 a.m. the DON indicated she understood there should be documentation to support why an antibiotic would be given for an extended length of time as well as follow up/reviews of the residents. During an Interview on 02/25/2026 at 11:00 a.m., the Administrator indicated she expected staff and physicians to follow protocols regarding antibiotic orders. Record review of an Antibiotic Stewardship Program Policy revised 10/01/22 indicated POLICY:The Community has a formal Antibiotic Stewardship Program (ASP) to optimize the treatment of infections, reduce the risk of adverse events, including the development of antibiotic-resistant organisms and employs Community-wide system to monitor the appropriate use of antibiotics.ANTIBIOTIC STEWARDSHIP PROGRAM (ASP) CORE ELEMENTS: 1. Leadership Commitment to demonstrate support and commitment to safe and appropriate antibiotic use in the community.7. Resources and education are provided to clinicians, nursing staff, residents and families about antibiotic resistance and opportunities for improving antibiotic use. b. Licensed independent practitioners (LIPs) are provided written education, the Community Antibiotic Stewardship Program and appropriate prescribing protocols upon credentialing and as needed. At the discretion of the Administrator or Community Medical Director, LIPs may be reeducated or provided with additional educational materials to improve antibiotic prescribing practices.ANTIBIOTIC STEWARDSHIP TEAM:The Community has an Antibiotic Stewardship Team to implement and direct the Core Elements of the ASP. The Team includes but is not limited to the following: .2. Medical Director or another licensed independent practitioner: a. Provides or assists in the provision of prescribing practices for credentialed clinical providers b. Oversees adherence to antibiotic prescribing practices for credentialed providers and offers written feedback regarding prescribing practices and compliance with antibiotic use protocols, which may include: .iii. Prescription documentation: indication for use, dosage, duration. iv. Clinical justification for use of an antibiotic beyond initial duration ordered.		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition for 1 of 1 stove in the kitchen reviewed for essential equipment. * The facility did not ensure the gas stove was in safe operating condition. The two right burners would not ignite when the knobs were turned. This failure could place the residents at risk of a fire for not having safe operating equipment. Findings included: During an observation and interview on 02/23/2026 at 08:53 a.m. the stove's two right burners were not lighting when the knobs turned on. Observation indicated the pilot lights to the two burners were not lit. The DM said they had to be lit with a long lighter. The DM said the stove should light without using a lighter. He said having to light the stove with a lighter could cause an explosion possibly causing injuries to residents. Observation indicated there was no hissing sound of gas and no foul smell of gas coming from the burners. During an interview on 02/24/26 at 11:05 a.m. the DM said the MD had looked at the stove after surveyor saw it and it still had a problem but there was no gas coming out unless the knobs were turned on. He said someone was supposed to be coming today to repair it. During an Interview on 02/25/26 at 11:00 a.m., the Administrator said she expected kitchen equipment to be working correctly. She said due to the stove being gas it could cause a fire and possible injuries. During an interview and record review on 02/25/26 at 11:30 a.m. the DM said someone had come and repaired the stove. He showed surveyor an equipment repair receipt for the stove. Record review of a Preventative Maintenance and Repair of Equipment policy dated 04/2022 indicated POLICY: The facility Plant Operations personnel will perform monthly inspections of kitchen equipment to ensure proper care of equipment and reduce cost by providing preventative maintenance in a timely manner. Record review of the FDA Food Code 2022 accessed on 02/25/26 at https://www.fda.gov/food/retail-food-protection/fda-food-code 4-5 Maintenance and Operation 4-501 Equipment 4-501.11 Good Repair and Proper Adjustment. (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2.		