

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: 455985	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2024
NAME OF PROVIDER OR SUPPLIER Clarksville Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 300 E Baker St 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48958 Based on interview, and record review the facility failed to treat each resident with respect and dignity that promoted maintenance or enhancement of quality of life for 1 of 14 residents reviewed for resident rights. (Resident #12) 1. The facility failed to treat Resident #12 with dignity and respect witnessed by Resident #43 when CNA D told Resident #12 Oh no ma'am, we are not fixing to do this because I am not going to be the one on 03/25/24 with an attitude and rude tone . These failures could place residents at risk for decreased quality of life, decreased self-esteem and increase anxiety. Findings included: 1. Record review of a face sheet dated on 09/17/2024 reflected Resident #12 was an [AGE] year-old female admitted to the facility on [DATE] with the diagnoses of slurred speech (weakness in the muscles used for speech, which often causes slowed or slurred speech), anxiety disorder unspecified (a diagnosis given when someone experiences clinically significant anxiety but doesn't meet the criteria for a specific anxiety disorder), muscle weakness (lack of muscle strength), and hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (a common after-effect of stroke that causes weakness on one side of the body). Record review of the quarterly MDS assessment dated [DATE] reflected Resident #12 had a BIMS score of 10, which indicated mild cognitive deficit. Resident #12 required maximal assistance for ADLs such as bed mobility, transfer, and toileting. Record review of a care plan dated 02/15/2024 titled ADL assistance reflected Resident #12 had an ADL self-care performance deficit and is at risk for not having their needs met in a timely manner. The intervention for Resident #12 revealed the staff was to provide shower, shave, oral care, hair care, and nail care (prefers longer nails) per schedule and when needed with ADL's. Prefers nails long. Won't use hand splint/roll or let you paint fingernails right hand. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/16/2024 at 10:47 a.m., Resident #43 said CNA D was rude to Resident #12. Resident #43 said Resident #12 tried to tell CNA D she was hurting her and grabbed her hand. CNA D grabbed Resident #12 hand and told her, Oh no ma'am you are not going to put your hands on me. Resident #43 said after that happened, she reported the incident to ADM and DON, and they took care of the situation. Resident #43 said the ADM and DON informed Resident #12 that she did not have to worry about anyone being mean to her here. Resident #43 said she thought CNA D does not work here anymore and she had not been back in their room since that incident. During an interview on 09/16/2024 at 3:17 p.m., Resident #12's family member stated there was an incident and she received information from the facility that a staff member had a bad attitude was rude to my mother. Resident #12 family member said she did not remember the details. During a phone interview on 09/17/24 1:32 p.m., CNA D said yes, I remember the incident with Resident #12. I weigh about 115 pounds. I wear a gait belt and it fits really loose, because I am so small. Resident #12 was very irritated that day I came in to work for someone else. I guess when I bent over to reposition her the metal part of the gait belt hit her and it made her upset. I apologized to her. Her oxygen nasal cannula was off and I was trying to put her stuffed animals back close to her and put her oxygen nasal cannula back on her face. She jerked the oxygen nasal cannula out of my hand and scratched me and I told her no ma'am; we are not going to do that, I am not going to be the one you put hands on today. CNA D said that was her first encounter with Resident #12. CNA D said she notified her charge nurse of the incident. CNA D said the nurse gave Resident #12 medication to relax her and after that she never went back into her room. CNA D said the facility fired her, so why are you calling me about the incident. CNA D said she was upset that day when she came in, because she was not informed by the facility staff that 5 residents on the hall, she was supposed to worked had Covid. During an interview on 09/18/2024 at 8:59 a.m., Resident #12 laid in bed awake. Resident #12 said she remembered CNA D. Resident #12 said CNA D hurt her feelings by the way she talked to her. Resident #12 said CNA D did not hit her. Resident #12 said she does feel safe at the facility. During an interview on 09/18/2024 at 9:10 a.m., LVN C said she knew CNA D. LVN C said when she worked with her, CNA D was a good aide. LVN C she had never heard CNA D be rude to staff or residents. LVN C said CNA D talked loud, but she was a good worker. LVN C said she was not there the day the incident occurred with CNA D and Resident #12. During an interview on 09/18/2024 at 9:32 a.m., CNA F said she remembered working with CNA D. CNA F said she had not witnessed CNA D be mean to the residents. CNA F said she had heard a couple of the residents said that CNA D had been rude to them. CNA F said Resident #43 told her that CNA D was rude, but she could not remember who the other resident was. CNA F said she had not seen CNA D be aggressive or mean toward the residents. (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/18/2024 at 9:49 a.m., DON said CNA D does not work here anymore. DON said the facility had an investigation about the incident with CNA D and Resident #12 witnessed by Resident #43. DON said Resident #12 and Resident #43 agreed the incident was not abuse. DON said after spoke to the nurses at the facility; they agreed that CNA D had a bad attitude. DON said CNA D worked at the facility as a shower aide before she started to work as needed. DON said since CNA D came back to work for facility; she complained about where she worked. DON said she tried to keep the same staff with the same residents, because everyone was like family there. DON said she got rid of CNA D, because of her constant bad attitude; not from the incident with Resident #12 particularly. DON said she does not need a bad attitude in her building. DON said she believed CNA D was rude to Resident #12 and Resident #43 and both residents said she was rude that day. During an interview on 09/18/2024 at 2:30 p.m., DON said she thought an attitude with a resident was not acceptable. DON said she believed bedside manners was better than medication given to a resident. DON said we should watch what we say and how we treat people. DON said the incident could probably affected Resident #12's dignity. DON said Resident #12 had trouble with communication, so she does not know the extent the incident effected Resident #12. During an interview on 09/18/2024 at 2:39 p.m., ADM said, the facility let CNA D go, because if she was going to have a bad attitude and the resident felt that she was expressing that negative attitude to them, then she was not a good fit for this facility. ADM said she was sure the incident with CNA D made Resident #12 feel sad and she thought the incident shocked Resident #12. ADM said they had never had an incident like that happened at the facility. ADM said the incident could had infringed on Resident #12's dignity, but more than that she thought her feelings were hurt. ADM said the negative effect that incident could had on Resident #12 was it could had made her sad or upset. Review of a Resident Rights facility policy dated 02/20/2021 reflected, .All residents will be treated equally regardless of age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex sexual orientation, or gender identity or expression.The facility will ensure that all staff members are educated on the rights of residents and the responsibility of the facility to properly care for its residents. These rights include the resident's right to .a dignified existence self-determination, and communication with and access to persons and services inside and outside the facility . Review of a Promoting/Maintaining Resident Dignity policy 02/16/2020 indicated, .It is the practice of the facility to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect.All staff members are involved in providing care to residents to promote and maintain resident dignity .		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46929 Based on interview and record review, the facility failed to ensure the Pre-Admission Screening and Resident Review (PASRR) Level I assessment accurately reflected the resident's status for 1 of 6 residents (Resident #24) reviewed for PASRR Level I screenings. 1. The facility failed to ensure the accuracy of the PASRR Level 1 screening for Resident #24. The PASRR Level 1 screening did not indicate a diagnosis of mental illness, although the diagnosis (PTSD with an onset date of 04/16/21) was present upon Resident #24's re-admitted on 05/17/2024. 2. The facility failed to ensure the accuracy of the PASRR Level 1 screening for Resident #24. The PASRR Level 1 screening did not indicate a diagnosis of mental illness, after a new diagnosis of major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), with an onset date of 08/28/24. The facility did not complete a 1012 form to update the PASRR Level 1 with the new diagnosis until surveyor intervention on 09/17/2024. This failure could place residents who had a mental illness at risk of not receiving a needed assessment (PASRR Evaluation), individualized care, or specialized services to meet their needs. Findings included: Record review of Resident #24's face sheet, dated 09/17/24, indicated he was a [AGE] year-old male, admitted to the facility on [DATE]. He was most recently readmitted to the facility on [DATE]. His diagnoses included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), with an onset date of 08/28/24, and post-traumatic stress disorder (a mental health condition that was caused by an extremely stressful or terrifying event), with an onset date of 04/16/21. Record review of Resident #24's quarterly MDS assessment, dated 08/06/24, indicated he had a BIMS score of 15, which indicated intact cognition. He also took an antidepressant medication during the assessment window. Record review of Resident #24's PASRR Level 1 Screening, printed on 07/07/23, indicated that in Section C Mental Illness was marked as no, which indicated Resident #24 did not have a mental illness. During an interview on 09/17/24 at 02:25 PM, Social Worker A said that Resident #24 was marked as negative for mental illness on his PASRR Level 1 screening. She said he had recently received a major depressive disorder diagnosis on 08/27/24. She said she did not know that PTSD could be a PASRR positive diagnosis. She said she was going to fill out a 1012 form to notify the local health authority of the resident's diagnosis change. During an interview on 09/18/24 at 02:14 PM, the Administrator said the PASRR Level 1 screening should have been marked yes for mental illness so the local health authority could evaluate him. She said it was possible he could have received PASRR services since August 28, 2024. (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy, Preadmission and Screening Resident Review (PASRR) Rules, last revised July 2023, stated: .It is the intent of Advanced Health Care Solutions to meet and abide by all state and federal regulations that pertain to resident preadmission and screening resident review (PASRR) rules . .Referring Entity completes a PL1 . .if negative: .If the resident has a qualifying MI (mental illness) diagnosis and the NF feels the resident should be positive they should talk to the referring entity and ask them to correct the PL1 or complete the 1012 .		

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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** 48958 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan to meet each resident's medical, nursing, mental and psychosocial needs for 1 of 6 residents reviewed for care plans. (Resident #28) The facility failed to implement Resident #28's signed physician order dated 03/31/2024 for occupational therapy to evaluate Resident #28 for a coffee lid. This failure could place residents at risk of not having individual needs met, a decreased quality of life, and cause residents not to receive needed services. Findings included: 1. Record review of a face sheet dated on 09/17/2024 indicated Resident #28 was an [AGE] year-old female admitted to the facility on [DATE] with the diagnoses of exudative age-related macular degeneration, left eye, stage, (a severe form of the disease that occurs when abnormal blood vessels grow under the retina and leak fluid and blood), muscle weakness (generalized) (lack of muscle strength), unsteadiness on feet (might occur due to vestibular problems, nerve damage to the legs, and neurological conditions, such as spondylosis), unspecified lack of coordination (can be a symptom of ataxia, a neurological condition that causes problems with muscle control) and cognitive communication deficit (a difficulty with communication that's caused by a disruption in cognition). Record review of the quarterly MDS assessment dated [DATE] reflected Resident #28 had a BIMS score of 9, which indicated mild cognitive deficit. Resident #28 was independent for ADLs such as eating and toileting but required setup with transfers. Record review of a care plan dated 10/03/2023 titled Visual function (impaired) indicated reflected, Resident #28 has impaired visual function and was at risk for falls, injury, and a decline in functional ability. The intervention for Resident #28 monitor/document/report to the physician the following signs and symptoms of acute eye problems: change in ability to perform ADLs, decline in mobility, sudden visual loss, pupils dilated, gray or milky pupils, complaints of halos around lights, double vision, tunnel vision, blurred vision, or hazy vision. Care plan date 09/19/2023 titled Falls indicated Resident #28 has the potential for falls related to severely impaired eyesight, generalized weakness, impaired coordination, anxiety, and history of falls while at home. Record review of Resident #28's nurses notes dated 03/30/2024 indicated Resident #28 had reported to the nurse, she had spilled a cup of coffee and received a small blister on her finger that did not require treatment. Resident #28 was educated on letting staff get her coffee. There were no witnesses to the incident. Record review of Resident #28's signed physician order dated on 03/31/2024 indicated Resident #28 was referred to occupational therapy for an evaluation for a lid to be placed on coffee cup. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review on Resident #28's Interdisciplinary Patient Screen dated 09/17/2024 indicated Resident #28, Patient was referred for screening in March 2024 and therapy was notified nursing recommended a screening for a cup lid, because of spill incident. Patient was screened by occupational therapy and based of observation and lack of any significant incident since no adaptive lid at this time. During observations on 09/16/2024 at 12:10 p.m., Resident #28 was eating lunch in dining area independently. Staff setup Resident #28's tray and told her where everything was on the tray before resident started to eat her meal. During an interview and observation on 09/17/2024 at 8:41 a.m., Resident #28 was observed transferred self from her wheelchair to her bed independently. Resident #28 said she did not remember telling anyone about incident where she spilled coffee on herself. Resident #28 said Honey, I'm blind and always spilling stuff on myself. Resident #28 said if there were staff in the dining room, she would let them get coffee for her. She said if there were no staff in the dining room and she wanted coffee then she would get it herself. She said there was 2 types of coffee containers, one had a pump on top and she had to wait on staff because she could not use it, but the other one had a lever, and she could use that fine. She said if she wanted coffee then she would go to get it, but she would let staff get it if they were there. She said she did not have a lid for her coffee but would not use one if she did. During an interview on 09/17/2024 at 9:10 a.m., COTA G was asked about Resident #28 orders for Refer to occupational Therapy to assess for a lid for a coffee cup. COTA G said Resident #28 had therapy before, but therapy had not received an order for a lid for a coffee cup evaluation, so there was no assessment performed. During an interview on 09/17/2024 at 9:20 a.m., The DON said if therapy does not have the assessment performed for an evaluation for the lid on the coffee cup, then the facility does not have one. DON said she did not know about the evaluation order and Resident #28 has not had any issues since the day she said she spilled the coffee. During a phone interview on 09/17/2024 at 10:06 a.m., MD said he expected the facility to follow his orders. MD said if the resident did not like the coffee cup lid he ordered, the facility could cancel the order for the coffee cup lid, but he wanted the orders followed. During an interview on 09/17/2024 at 10:54 a.m., LVN E said Resident #28 told her she spilled coffee on her finger earlier that day and had not told reported it to staff. LVN E said she asked Resident #28 why she did not report the incident to staff about she had spilled coffee on her finger. LVN E said Resident #28 told her she felt like it was not a big deal, and she felt like it was not important, but she told her friends about the (coffee spill) incident and they told Resident #28 she should have told the nurse, so she told LVN. E LVN E said she educated Resident #28 on when things happened in the future let staff know, so they can take care of it. LVN E said her intervention was to educate Resident #28 and to notify occupational therapy to maybe get a coffee cup with a lid. LVN C said all nurses were responsible to make sure doctor orders were followed. LVN E said she did not write an order for occupational therapy to evaluate Resident #28 for a cup with a lid; that was an intervention. LVN E said if she wrote an order, it was a mistake; it was supposed to be an intervention. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/18/2024 at 9:10 a.m., LVN C said when a nurse received an order from the doctor the nurse was responsible for following through with the order. LVN C said when doctor orders are put into point click care therapy were able to access the orders the nurse applied to the computer system. LVN C said the nursing staff usually informed therapy about the new doctor's orders verbally. LVN C said when a nurse wrote an order for an evaluation for therapy, it would be therapy responsibility to follow and initiate the order. LVN C said a signed doctor order should be followed. During a phone interview on 09/18/2024 at 9:49 a.m., the DON said the MD did not write the order for occupational therapy evaluation. LVN E called another MD for the order, but it was not an order. The DON said LVN E wrote an intervention. The DON agreed MD signed the order. The DON said the facility intervention was for Resident #28 coffee spill was to educate the resident on getting assistance with the coffee. The DON said when the nurses put in doctor orders, she expected the nurses to follow the orders. DON said she does believe when a true doctor order was wrote, the orders should be followed, but that was not a doctor order; it was an intervention. During an interview on 09/18/2024 at 2:30 p.m., the DON said she expected the nurses to follow doctor's orders. The DON said not, following doctor orders could affect the residents in several different ways. DON said all signed doctor orders should be followed. During an interview on 09/18/2024 at 2:39 p.m., ADM said she expected the nurses to follow doctor's orders. ADM said not following doctor's orders could potentially cause issues for the resident, if the facility does not follow the doctor orders. ADM said when an order was signed by the doctor, she expected the staff to follow signed doctor's orders. Record review of a facility's Comprehensive Care Plans policy dated 02/10/2021, indicated .to meet the resident's physical, psychosocial and functional needs is developed and implemented for each residents .the care planning process will .include an assessment of the resident's strengths and needs .incorporate the resident's personal and cultural preferences .the services that are to be refurbished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being . Record review of a facility's Following Physician Orders policy dated 02/10/2021 indicated . for consulting physician/practitioner orders received in writing or via fax, the nurse in a timely manner will: follow facility procedures for verbal or via telephone orders including noting the order, submitting to pharmacy, and transcribing to medication or treatment administrator record .		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46929 Based on observation, interview, and record review the facility failed to ensure a resident who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals, and preferences for 1 of 2 residents (Resident #147) reviewed for respiratory care and services. The facility failed to change the filter on an oxygen concentrator machine that were in use for Resident #147 on 09/16/24. This failure could place residents at risk for developing respiratory complications. Findings included: Record review of Resident #147's face sheet, dated 09/17/24, indicated he was a [AGE] year-old male, admitted to the facility on [DATE]. His diagnoses included heart failure (a chronic condition in which the heart is unable to pump blood effectively), and shortness of breath. Review of Resident #147 MDS reflected they did not have an OBRA MDS assessment completed at the time of this visit. It was not yet due to be completed. During an observation and interview on 09/16/24 at 9:53AM, Resident #147 was lying in bed in his room. He had oxygen in place via a nasal cannula. The oxygen concentrator filter was dirty with a thick layer of white/gray material on the surface. Resident #147 said he usually wore oxygen. During an observation on 09/16/24 at 12:18 PM, Resident #147 was lying in bed in his room. He had oxygen in place via a nasal cannula. The oxygen concentrator filter was still dirty with a thick layer of gray/white material. During an observation on 09/16/24 at 03:06 PM, Resident #147 was lying in bed in his room. He had oxygen in place via a nasal cannula. The oxygen concentrator filter was dirty with a thick layer of gray/white material. During an interview on 09/18/24 at 11:24 AM, LVN B said she had taken care of Resident #147 on 09/16/24. She said she did not check the concentrator filter on the machine during her shift. She said the filters were normally checked weekly. She said she had worked full-time at this facility for only the past few weeks. She said the risk to Resident #147 was that he could get sick or suffer respiratory distress. She said he had been admitted over the past weekend. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/18/24 at 11:26 AM, LVN C, Hall Manager, said she had worked on 09/16/24 and went into Resident #147's room a few times. She said the nurses were supposed to check the concentrator filters once a week on night shift on Wednesdays. She said that Resident #147 had been recently admitted over the weekend, and it was possible that the filter had not been changed from the last time the concentrator was used. She said some of the concentrators did not take filters, so the nurses sometimes forgot to check the filter. She said she did not think the resident could get sick from the dirty filter because the machine would shut off before the resident would get sick. She said even though the machine was working on 09/16/24 with the dirty filter, she did not think the resident would get sick. She said if the machine shut off, then she would be worried about respiratory distress. During an interview on 09/18/24 at 01:44 PM, the ADON said the nurses were supposed to check the filters every week when the tubing was changed. She said she expected the nurse that had pulled the concentrator out of storage to look at it and check the filter. She said the risk to the resident could be that he could get sick from the dirty filter. During an interview on 09/18/24 at 01:53 PM, the DON said the nurses checked and changed filters every Wednesday. She said she did not catch it on Monday before this surveyor checked it. She said the risk to the resident could be sickness. During an interview on 09/18/24 at 02:14 PM, the Administrator said she expected the staff to keep the filter clean and change it per policy. She said the risk to the resident could be sickness. Record review of the facility's policy, Oxygen Administration, last reviewed 01/05/20, stated: .Concentrator 1. Clean filter weekly 2. Remove filter from back of concentrator 3. Rinse filter with water 4. Shake off excess water. Replace filter .		