

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

Printed: 07/18/2026
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 12/10/2025
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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident for 4 of 5 residents (Resident #2, Resident #7, Resident #8, and Resident #11) reviewed for trauma-informed care. The facility did not ensure the care plans of Resident #2, Resident #7, Resident #8, and Resident #11, who had histories of trauma, identified possible triggers and interventions. This failure could place residents at an increased risk for severe psychological distress due to re-traumatization. 1. Record review of Resident #2's face sheet, dated 12/10/25, reflected Resident #2 was a [AGE] year-old male, originally admitted to the facility on [DATE] with diagnoses which included PTSD (a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event). Record review of Resident #2's quarterly MDS, dated [DATE], reflected Resident #2 made himself understood and understood others. Resident #2's BIMS score was 9, which indicated his cognition was moderately impaired. Resident #2 had a diagnosis of PTSD and depression. Record review of Resident #2's comprehensive care plan, revised 07/31/25 reflected Resident #2 had a history of trauma that may have a negative effect related to PTSD. The care plan interventions included: monitor for signs and symptoms of depression, anxiety, sleep disturbances and substance abuse issues. The care plan did not address triggers. Record review of Resident #2's comprehensive trauma screening, dated 01/17/25, reflected it did not address triggers. During an interview on 12/10/25 at 10:00 a.m., Resident #2 stated he had a diagnosis of PTSD. Resident #2 stated he had not identified any triggers within the facility and there was nothing that bothers him. Resident #2 stated however he did get spooked when he was woken up. 2. Record review of Resident #7's face sheet, dated 12/10/25, reflected Resident #7 was a [AGE] year-old male, originally admitted to the facility on [DATE] with diagnoses which included PTSD (a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event), anxiety, depression, and psychotic disorder (severe mental disorders that cause abnormal thinking and perceptions) with hallucinations (sensory experiences, like seeing hearing or feeling things that are not real). Record review of Resident #7's quarterly MDS, dated [DATE], reflected Resident #7 sometimes made himself understood and usually understood others. Resident #7's BIMS score was 8, which indicated his cognition was moderately impaired. Resident #7 had a diagnosis of PTSD anxiety, depression, and (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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	psychotic disorder with hallucinations. Record review of Resident #7's comprehensive care plan, revised 09/16/25 reflected Resident #7 used psychotropic medications, mood stabilizer, antidepressants, antianxiety, antipsychotics related to PTSD, major depression disorder, and psychotic disorder with hallucinations. The care plan intervention included: administer medication as ordered, and monitor/document for side effects and effectiveness. The care plan did not address Resident #7's history of trauma to include potential triggers for re-traumatization. Record review of Resident #7's comprehensive trauma screening, dated 11/08/24, reflected it did not address triggers. During an interview on 12/10/25 at 10:07 a.m., the Social Worker stated the comprehensive trauma screening was completed by her on admission. The Social Worker stated she did not ask about the triggers when completing the comprehensive trauma screening. The Social Worker stated she had never been told to ask about triggers unless the resident or family volunteered the information. The Social Worker stated the care plan should indicate whether the resident had triggers or not. After reviewing Resident #2 and #7's electronic medical records, the Social Worker stated neither resident had triggers noted and to her knowledge Residents #2 and #7 did not have any triggers. The Social Worker stated it was important to ensure triggers were identified to prevent re-traumatization. During an interview on 12/10/25 at 10:42 a.m., Resident #7's family member stated he had a diagnosis of PTSD. Resident #7's family member stated he had no significant triggers; however, he does have dreams about his PTSD. Resident #7's family member described it as lookbacks from being in the Vietnam war. During an interview on 12/10/25 at 11:07 a.m., CNA G stated she provided care to Resident #2. CNA G stated to her knowledge Resident #2 did not have any trigger or a diagnosis of PTSD. CNA G stated it was important to know resident's triggers to look out for the warning signs. During an interview on 12/10/25 at 11:32 a.m., CNA H stated she was Resident #7's aide for the 6a-6p shift. CNA H stated to her knowledge Resident #7 did not have any triggers or a diagnosis of PTSD. CNA H stated if the resident did or did not have triggers it should be documented in his chart. CNA H stated it was important to know resident's triggers to prevent re-traumatization. During an interview on 12/10/25 at 5:48 p.m., the MDS Coordinator stated the care plan should indicate whether the residents have triggers or not. After reviewing Resident #2 and #7's electronic medical records, the Social Worker stated neither resident had triggers noted and to her knowledge Residents #2 and #7 did not have any triggers. The MDS Coordinator stated it was important to know resident's triggers to prevent traumatization. During an interview on 12/10/25 at 6:54 p.m., the DON stated she expected triggers to be identified on the care plan. The DON stated the Social Worker and MDS Coordinator were responsible for ensuring the triggers were identified and documented in the resident's chart. The DON stated the Administrator was responsible for monitoring and overseeing PTSD/triggers. The DON stated it was important to know resident's triggers to help better care for the resident. An attempted telephone interview on 12/10/25 at 7:30 p.m., with the Administrator was unsuccessful. (continued on next page)		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #8's face sheet dated 12/10/2025 revealed a [AGE] year-old female originally admitted [DATE] and readmitted [DATE] with diagnoses including post-traumatic stress disorder, cerebral palsy (a neurological condition from brain damage affecting movement, posture and coordination), schizoaffective disorder (a mental illness blending symptoms of psychosis like hallucinations & delusions with mood disorders and mood swings), mild intellectual disabilities, and anxiety (a feeling of unease, worry or fear). Record review of Resident #8's comprehensive MDS dated [DATE] revealed a BIMS score of 15 indicating intact cognition and active diagnosis of PTSD. Further review of Resident #8's comprehensive MDS dated [DATE] revealed Resident #8 utilized a wheelchair for mobility, was independent in eating, required moderate assistance in bathing, maximum assistance in toileting, bed mobility, transfers and total assistance in upper and lower body dressing. Record review of Trauma Assessment Screening form (date not obtained) revealed no identified triggers or description of PTSD event. Record review of Resident #8's care plan with target date of 02/02/2026 revealed Resident #8 was identified as having a history of trauma that may have a negative effect. The care plan did not identify the type of trauma experienced and provided no interventions to ensure Resident #8's needs were being met. During an interview on 12/09/2025 at 11:25 a.m., Resident #8 appeared hesitant to discuss her trauma history with surveyor and was unable to provide further information regarding triggers for care. During a phone interview on 12/11/2025 at 2:20 p.m., Resident #8's family member stated that the trauma stemmed from her former marriage where she experienced an abusive family member. Resident #8's family member stated that Resident #8 appears content in the facility and that a possible trigger could be an aggressive male or a male that resembled her family member. During an interview on 12/10/2025 at 10:11 a.m., the Social Worker stated that she completes the trauma assessment on admission only for residents and stated that the trauma assessment does not ask for triggers. The Social Worker stated that identification of triggers specific to each resident would be important to know to help avoid exacerbation of trauma / PTSD. The Social Worker stated she does not ask each resident specifically what the triggers are, but she does explore the PTSD, document concerns and refer to psychological care services for on-going management. During an interview on 12/09/2025 at 9:58 a.m., CNA A stated that she is aware Resident #8 has some outbursts at times but has not been informed of any trauma triggers to be mindful of. During an interview on 12/09/2025 at 3:09 p.m., LVN B stated that she is aware Resident #8 receives medication for mood and behavior management, but is not aware of specific areas of concern related to trauma. During an interview on 12/09/2025 at 3:20 p.m., CNA C stated she works well with Resident #8 and knows that she becomes upset at times but she can easily calm her down. CNA C stated she has not been advised of specific concerns for Resident #8 related to PTSD and that she could not recall if she has received training for PTSD in the past year. During an interview on 12/10/2025 at 1:55 p.m., LVN D stated that she knows Resident #8 receives psychological services and behavior medications but she was not aware of what Resident #8's (continued on next page)		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	trauma is related to or what triggers to watch for. During an interview on 12/10/2025 at 6:54 p.m., the DON stated she expects triggers to be identified on the care plan however she feels her staff know the residents well enough that no harm has come from not having this information available for all staff. The DON stated that the Social Worker and the MDS Nurse are responsible for completing the Trauma Informed Care Assessment and stated it is important that triggers are identified to ensure quality of care for the residents affected by PTSD. The DON stated she and the Administrator are ultimately responsible for ensuring assessments are completed. Record review of Resident #11's face sheet dated 12/10/25 indicated he was a [AGE] year-old male who re-admitted to the facility on [DATE] with the diagnoses PTSD, Dementia (cognitive decline that affects daily life caused by brain cell damage), major depressive disorder (persistent sadness, loss of interest, fatigue, and change in sleep/appetite), diabetes mellitus (chronic metabolism condition marked by high blood sugars), and presbyopia (natural age-related loss of eye's ability to focus on nearby objects). Record review of Resident #11's quarterly MDS dated [DATE] indicated he could make himself understood and was able to understand others. The MDS also indicated he had a BIMS score of 15 which meant his cognition was intact. The MDS also indicated he was independent with all ADLs. Record review of Resident #11's care plan dated 02/22/22 indicated he had a history of trauma that may have a negative effect related to his diagnosis of PTSD due to military history with a goal of staff assist Resident #11 in avoiding his triggers. The care plan did not indicate what Resident #11's triggers were. Record review of Resident #11's comprehensive trauma screening assessment dated [DATE] completed by the Social Worker indicated he had a documented diagnosis of trauma but the assessment did not indicate if Resident #11 had triggers nor what the triggers were. During an interview on 12/10/25 at 10:25 AM the Social Worker said Resident #11 had triggers that consisted of him not liking loud noises. The Social Worker said yesterday (12/09/25) the facility had fire drills and she felt like she should have gone to Resident #11 and let them know there was going to be loud noises [KS1] and that she maybe should have stayed with Resident #11 to comfort him. The Social Worker said the staff would know what Resident #11's triggers were because he was very vocal and would let them know. The Social Worker said there were no triggers on Resident #11's care plans but there should have been triggers included in his care plan to prevent more trauma. During an interview on 12/10/25 at 11:34 AM CNA H said she did not know about Resident #11 having PTSD, but he provided his ADLs for himself. CNA H said she was not aware of him having PTSD, but he would talk with her if he needed anything. CNA H said all staff should be aware if residents had a diagnosis of PTSD to prevent problems. Record review of the facility's policy titled Trauma Informed Care dated 10/24/22 indicated. it is the policy of this facility to provide care and services which, in addition to meeting professional standards, are delivered using approaches which are culturally-competent, account for experience and preferences, and address the needs of trauma survivors by minimizing triggers and/or re-traumatization. 4. The facility will collaborate with resident trauma survivors, and as appropriate, the resident's family, friends, the primary care physician, and any other health care professionals (continued on next page)		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(such as psychologists and mental health professionals) to develop and implement individualized care plan interventions. 6. The facility will identify triggers which may re-traumatize residents with a history of trauma. Trigger-specific interventions will identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident and will be added to the resident care plan.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that it was free from a medication error rate of 5 percent or greater. The facility had a medication error rate of 8.82 %, based on 3 errors out of 34 opportunities, which involved 3 of 5 residents (Residents #15, #26, and #27) reviewed for medication administration. 1. The facility failed to ensure LVN K administered insulin correctly for Resident #15. 2. The facility failed to ensure RN B administered Aspirin 325 mg (a common strength of the nonsteroidal anti-inflammatory drug (NSAID) used for pain/fever relief (headaches, colds, arthritis) and, at the doctor's direction, for heart/stroke prevention by reducing blood clots) as ordered by the physician for Resident #26 on 12/08/25. 3. The facility failed to ensure RN B administered Cyanocobalamin 2500 mcg (medication used to maintain the health of your metabolism, blood cells, and nerves) as ordered by the physician for Resident #27 on 12/08/25. These failures could place residents at risk of not receiving the intended therapeutic benefit of their medications or receiving them as prescribed by the physician's orders. Findings included: 1. Record review of Resident #15's face sheet, dated 12/10/25, reflected Resident #15 was a [AGE] year-old male, admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included Type 2 diabetes mellitus (lifelong condition where the pancreas makes little or no insulin, which leads to high blood sugar levels), stroke, and high blood pressure Record review of Resident #15's quarterly MDS assessment, dated 11/26/25, indicated Resident #15 made himself understood and understood others. Resident #15's BIMS score was 15, which indicated his cognition was intact. The MDS indicated he received insulin over the 7-day look-back period. Record review of Resident #15's comprehensive care plan dated 08/16/23 indicated Resident #15 had diabetes mellitus. The care plan interventions were for staff to check his blood sugars, give diabetes medication as ordered, observe for adverse side effects and/or complications such as hypoglycemia. Record review of the physician order summary report, dated 10/23/25, reflected Resident #15 had an order for: -NovoLog Flex Pen Subcutaneous Solution Pen injector 100 units per milliliter (Insulin Aspart) Inject 20 units subcutaneously before meals for diabetes. -NovoLog Flex Pen Subcutaneous Solution Pen injector 100 units per milliliter (Insulin Aspart) Inject as per sliding scale: if 200 - 250 = 2 units; 251 - 300 = 4 units; 301 - 350 = 6 units; 351 - 400 = 8 units; 401 -450 = 10 units if over 400, contact primary physicians. Subcutaneously before meals and at bedtime, related to diabetes. During an observation and interview on 12/08/25 at 10:53 a.m., LVN K took Resident #15's blood sugar with a reading of 292. LVN K prepared Resident #15's Novolog by removing the pen cap, placing a needle onto the pen, and turning the dose knob to 24 units. LVN K administered the medication to Resident #15's right arm. LVN K did not prime (removing the air from the needle and cartridge) the insulin pen by turning the dose knob to 2 units before turning the dose knob to 24 units. LVN K said she was unaware she needed to prime the insulin before administering Resident #15's insulin. LVN K said after being questioned that she could see the importance of priming the insulin pen to ensure the resident received the correct dosage of insulin, which could have led to uncontrolled diabetes. 2. Record review of Resident #26's face sheet dated 12/10/25, indicated a [AGE] year old female who admitted to the facility on [DATE] with diagnoses which included heart failure (a serious condition that occurs when the heart can't pump enough blood to meet the body's needs), high blood pressure, kidney failure (a condition in which one or both of your kidneys no longer work on their own), and diabetes mellitus type 2 (also known as diabetes, a chronic disease that occurs when the body has high blood sugar levels. Record review of Resident #26's annual MDS assessment dated [DATE], indicated Resident #26 understood and was understood by others. The MDS assessment indicated Resident #26 had a BIMS score of 11, indicated her cognition was moderately impaired. The MDS assessment indicated Resident #26 had received an antiplatelet medication within the last 7 days of the look-back period. Record review of Resident #26's comprehensive care plan revised on 09/03/25, indicated (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #26 was taking an anticoagulant related to her disease process of high blood pressure, heart issues, and kidney disease. The care plan interventions were for staff to give diabetes medication as ordered by the doctor. Record review of Resident #26's order summary report dated 06/01/25, indicated Resident #26 had an order for the following: Aspirin Oral Tablet 325 MG (Aspirin). Give 1 tablet by mouth in the morning for the heart. During an observation on 12/09/25 at 9:59 a.m., RN B checked the MAR for Resident #26 and then gave 1 tablet of Aspirin 81mg. During an interview on 12/09/10 at 12:58 p.m., RN B said she gave Resident #26, 1 tablet of Aspirin 81 mg. She said that since the order read to give 1 tablet of Aspirin 325mg, but she gave 1 tablet of Aspirin 81mg, she gave the wrong dose. She said she pulled the wrong bottle, and the risk could affect her clotting factor. 3. Record review of Resident #27's face sheet dated 12/10/25, indicated an [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included vitamin B deficiency (occurs when your body lacks sufficient B vitamins, leading to symptoms like extreme fatigue, weakness, pale skin, mood changes (depression, irritability), numbness/tingling, mouth sores, and cognitive issues (memory problems, confusion), and dementia (a loss of mental functions that is severe enough to affect your daily life and activities). Record review of Resident #27's quarterly MDS assessment dated [DATE], indicated Resident #27 understood and was understood by others. The MDS assessment indicated Resident #27 had a BIMS score of 05, indicating his cognition was severely impaired. The MDS assessment did not indicate Resident #27 had received Cyanocobalamin. Record review of Resident #27's comprehensive care plan revised on 08/25/25, indicated Resident #27 had impaired cognition and was at risk for a further decline in cognitive and functional abilities related to dementia. The care plan interventions were for staff to give medication as ordered by the doctor. Record review of Resident #27's order summary report dated 05/30/25, indicated Resident #27 had an order for the following: Cyanocobalamin Tablet 1000 MCG. Give 2.5 tablets by mouth in the morning for the supplement; take 2.5 tabs to equal a 2500 mcg dose. During an observation on 12/09/25 at 10:07 a.m., RN B checked the MAR for Resident #27 and then gave 2.5 tablets of Cyanocobalamin 500 Mcg. During an interview on 12/10/10 at 12:47 p.m., RN B said she gave Resident #27, 2.5 tablets of Cyanocobalamin 500 Mcg. She said that since the order read to give 2.5 tablets of Cyanocobalamin 1000 Mcg, she gave 2.5 tablets of Cyanocobalamin 500 Mcg, she gave the wrong dose. She said the failure was she gave the wrong ordered dosage, and he did not receive the therapeutic dose he needed. During an interview on 12/10/25 at 7:00 p.m., the DON said she expected nurses to give insulin and other medication correctly. The DON said she expected the nurses to read the MAR and give medication as ordered. The DON said she was not sure of what the policy said on insulin pen administration, but after reading the manufacturer's insert on insulin pens, she said she would do an in-service about priming the insulin pens before each use. She said if the pen was malfunctioning, then a resident might not receive the correct dose of insulin, which could make their blood sugar level rise, and if they did not receive the ordered dose, they may not be receiving the therapeutic dose. During an attempted phone interview on 12/10/25 at 7:30 p.m., the Administrator was unsuccessful. Record review of the undated facility's Licensed Nurse Skills Review indicated #1 Perform hand hygiene, #2 Check the physician's order for insulin, #5 Prepare injection: attach the needle, remove the needle cap, check the flow of delivery (air shot) with a 2 unit prime every time and then select the dosage. Record review of the facility's policy titled, Medication-Treatment Administration and Documentation Guidelines, revised 04/06/23, indicated To provide a process for accurate, timely administration and documentation of medication and treatment. Fundamental information: medications are administered according to the manufacturer's guidelines unless otherwise indicated by physician orders. Process: #1 Verify labels accurately reflect the physician's orders on the electronic medical administration record before administering residents' medications and treatment, #2 verify administration accuracy by checking the medication with the MAR three times, #4 administer the medication according to the physician's order. Record review of the manufacturer's policy titled Insulin Aspart Recombinant Novolog, indicated, Insulin was a fast-acting type of insulin. Insulin is one (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of many hormones that help the body turn the food we eat into energy. To use the flex pen or flex touch pen: #1 wash your hands, #2 primed the pen by removing the air from the needle and cartridge, Select 2 units when turning the dose knob, #3 hold the pen with the needle pointing up then gently tap the cartridge holder to collect the air bubbles at the top, #4 press the push button until it stops you should see a zero in the dose window, #5 you should see insulin at the needle tip if you do not see anything repeat the priming steps but not more than six times if there is still no answer do not use the pen.#6 turn the dose selector, be careful not to press the button #7 insert the needle into your skin and press the push button all the way in for at least 6 seconds. Keep pressing until the needle has pulled out from the skin. This will make sure that you have received the full dose.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, interviews, and record reviews, the facility failed to provide food that was palatable, attractive, and at a safe and appetizing temperature for 9 of 9 confidential residents reviewed for food and nutrition services. The facility failed to ensure dietary staff provided food that was palatable and had an appetizing temperature on 12/09/25. This failure could place residents at risk of decreased food intake, hunger, and unwanted weight loss. Findings included: During a confidential resident group meeting 9 residents stated the food was lousy and cold. During an observation and interview on 12/09/25 at 12:16 p.m., lunch tray was sampled by the Dietary Manager and six surveyors. The sample tray consisted of chili bake which was lukewarm, carrots which were lukewarm, and salad was brown, soggy and withered. The Dietary Manager stated the chili bake and carrots was good to her, and salad was alright. During an interview on 12/10/25 at 4:37 p.m., CNA L stated residents had stated the food was not that great. CNA L stated she was unable to recall the resident's name. CNA L stated when they complained she would try to season the food with the salt and pepper that was given on the tray or offer the resident an alternative. CNA L stated she did not report the complaints to anyone. CNA L stated residents not eating their food could potentially cause weight loss. During an interview on 12/10/25 at 4:51 p.m., the ADON stated no residents complained to her about food being cold or bland but if so, she would offer the resident an alternative. The ADON stated all food complaints would be reported to the DON and Dietary Manager. The ADON stated it was important to ensure food was palatable and had an appetizing temperature to ensure the residents get the nutrition they need. During an interview on 12/10/25 at 6:08 p.m., the Dietary Manager stated she has not had any complaints regarding food being cold or food tasting bland in the last several months. The Dietary Manager stated food complaints were usually brought to her verbally and an alternative would be offered. The Dietary Manager stated she monitored meal service daily including random tray sampling. The Dietary Manager stated it was important to ensure food was palatable and had an appetizing temperature to prevent weight loss. During an interview on 12/10/25 at 6:54 p.m., the DON stated she expected food to be the appropriate temperature and seasoned for palatability. The DON stated the Administrator was responsible for monitoring and overseeing. The DON stated it was important to ensure food was palatable and had an appetizing temperature to keep up their nutrition and quality of life. An attempted telephone interview on 12/10/25 at 7:30 p.m., with the Administrator was unsuccessful. Record review of the facility's policy titled Dietary Services Manager's Responsibility revised 01/2013 indicated. The Dietary Service Manager or designee is responsible for ensuring proper preparation of food by methods that conserve nutritive value, flavor and appearance. 2. The dietary service manager or designee should taste all foods prior to serving. 3. The dietary service manager or designee should see that all meals are presented in a manner that enhances plate appearance.		

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NAME OF PROVIDER OR SUPPLIER Clarksville Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 300 E Baker St Clarksville, TX 75426	
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety for 1 of 1 kitchen reviewed. The facility did not ensure: 1. Food items were labeled and dated. 2. Hair restraints were worn. 3. The kitchen staff had a Soap dispenser located in a place that did not prevent the staff contaminating the clean dish rack. These failures could place residents at risk for foodborne illness. Findings included: During the initial tour observation and interview with the Dietary Manager on 12/08/25 beginning at 11:02 a.m., the following was revealed: 1. Two cans of cut sweet potatoes undated. During an observation on 12/08/25 at 11:05 a.m., the soap dispenser was located over the clean dish rack next to the three-compartment sink. During an observation on 12/08/25 at 11:10 a.m. [NAME] O, [NAME] P and Dietary Manager hairnet were not covering her entire head while she prepared the lunch meal. There was loose hair sticking out. During an interview on 12/10/25 at 5:09 p.m., Dietary Aide F stated all staff were responsible for labeling and dating. Dietary Aide F stated hair nets should always be worn while in the kitchen and cover the entire head without loose hair sticking out. Dietary Aide F stated these failures could potentially put residents at risk for food borne illness and cross contamination. During an interview on 12/10/25 at 5:18 p.m., [NAME] Q stated all staff were responsible for labeling and dating. [NAME] Q stated hair nets should always be worn while in the kitchen and hairnets were supposed to cover the entire head without loose hair sticking out. [NAME] Q stated these failures could potentially put residents at risk for foodborne illness and cross contamination. An attempted telephone interview on 12/10/25 at 5:21 p.m., with [NAME] O was unsuccessful. An attempted telephone interview on 12/10/25 at 5:25 p.m., with [NAME] P was unsuccessful. During an interview on 12/10/25 at 6:08 p.m., the Dietary Manager stated cleanliness was important in the kitchen, so staff were not spreading germs or contaminating anything. The Dietary Manager stated she was responsible for making sure the kitchen was cleaned appropriately. The Dietary Manager stated all food should be dated by the date received. The Dietary Manager stated hair nets should be worn while in the kitchen and covering the entire head without loose hair sticking out. The Dietary Manager stated the soap dispenser should not be over the clean dishes. The Dietary Manager stated she had reported to the department head about moving the soap dispenser. The Dietary Manager stated she was unable to recall names. The Dietary Manager stated she was responsible for monitoring and overseeing daily walk throughs and when there was an isolated issue that staff were verbally in service. The Dietary Manager stated these failures could potentially put residents at risk for cross contamination and foodborne illness. An attempted telephone interview on 12/10/25 at 6:22 p.m., with the Dietitian was unsuccessful. During an interview on 12/10/25 at 6:54 p.m., the DON stated food items should be dated. The DON stated hair nets should be worn while in the kitchen and covering the entire head without loose hair sticking out. The DON stated the soap dispenser should not be over the clean dish rack. The DON stated the Administrator was responsible for monitoring and overseeing. The DON stated these failures could potentially put residents at risk for cross contamination and foodborne illness. An attempted telephone interview on 12/10/25 at 7:30 p.m., with the Administrator was unsuccessful. Record review of the facility's policy titled Dietary Services Manager's Responsibility revised 01/2013 indicated. The Dietary Service Manager or designee is responsible for ensuring proper preparation of food by methods that conserve nutritive value, flavor and appearance. 6. The dietary service manager or designee must ensure that dietary staff practice hygienic food handling techniques at all times. Record review of the facility's policy titled Dry Food and Supplies Storage revised 11/15/17 did not address dating food that was in its original container.		

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents the right to participate in the development and implementation of his or her person-centered plan of care for 1 of 6 residents (Resident #47) reviewed for care plans. The facility failed to invite and include the input of Resident #47 and/or the resident's representative as members of the interdisciplinary team in Care Plan Conference meetings. This failure could place residents at risk of not receiving the interventions, treatments, and care necessary for the resident to reach their highest practicable physical, mental, and psychosocial well-being by not involving the resident and/or the resident's representative in Care Plan Conference meetings. The findings included: Record review of Resident #47's face sheet, dated 10/12/2025 revealed a [AGE] year-old female admitted [DATE] with diagnoses including cerebral infarction (occurs when a blood clot blocks an artery in the brain, cutting off oxygen and nutrients leading to brain tissue death) with Right sided weakness, hypertension (high blood pressure), dysphagia (difficulty swallowing), aphasia (difficulty speaking), and visuospatial deficits (difficulties with processing and interpreting visual information). Record review of Resident #47's comprehensive MDS dated [DATE] revealed a BIMS score of 10 indicating moderate cognitive impairment. Further review of Resident #47's comprehensive MDS dated [DATE] revealed Resident #47 presented with upper and lower extremity range of motion impairment, required a wheelchair for mobility, set-up assistance in self-feeding, was dependent in toilet hygiene, bathing and transfers, required moderate assistance in upper body dressing and maximum assistance in lower body dressing, and bed mobility. A record review of Resident #47's care plan revealed the care plan was initiated on 11/05/2025 and completed on 11/24/2025. The record did not include an invitation for Resident #47 and/or the Responsible Party to the care plan meeting or a signature sheet of attendees. During an interview on 12/08/2025 at 1:03 p.m., Resident #47 stated she talks a lot with the therapy staff but has not attended or been informed of a Care Plan Conference meeting with the Social Worker, Activity Director or nursing staff. Resident #47 stated she signed her own paperwork when she was admitted to the facility. During an interview on 12/11/25 at 9:09 a.m., Resident #47's family member stated that she was not invited to or informed of a Care Plan Meeting since Resident #47 was admitted. Resident #47's family member stated she was visiting Resident #47 on 12/10/25 when she was approached by the Social Worker to go to a meeting to discuss concerns the family member had addressed to the nurses over the previous weekend. During an interview on 12/10/25 at 5:20 PM, the MDS Nurse stated that a Care Plan review was completed 11/24/25. The MDS Nurse stated neither the resident nor the family members were present at the review. The MDS Nurse stated that she believes the Social Worker is responsible for inviting the resident or the family to the meetings. The MDS Nurse stated that failure to include residents in their plan of care could result in them not being fully aware of their medications, treatments and rights. During an interview on 12/10/2025 at 5:23 p.m., the Social Worker stated that a Care Plan meeting was held this morning with Resident #47's family members. The Social Worker stated that this was an impromptu meeting when she was notified that the family had some concerns and that they were present in the facility. The Social Worker stated that she is responsible for informing and inviting residents and/or responsible parties to the Care Plan conference meeting which should be completed within three weeks of admission. The Social Worker stated a Care Plan review was already completed for Resident #47 and she failed to invite the resident or responsible party to the review meeting. The Social Worker stated that she should have notified Resident #47 of the care plan review meeting, that it is important to involve the Resident in the meetings to ensure he/she is aware of all aspects of his/her care and failure to include them could result in missing some important concerns about care. During an interview on 12/10/25 at 6:54 p.m., the DON stated that a baseline care plan should be completed within 72 hours (continued on next page)		

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of admission and a full care plan should be completed by day 21 of the resident's stay. The DON stated she expects the Interdisciplinary Team Members to include the Social Worker and MDS Nurse to ensure the resident and/or their Responsible Party participate in the care plan conference meeting either in person or by phone if necessary to ensure they are informed of the care plan findings and involved in the plan of care. The DON stated adverse effect of residents or their representative not attending and participating in review meetings would be that decisions could be made that the resident and/or representative were not aware of or were not congruent with their wishes. An interview was attempted on 12/10/25 at 7:31 p.m. with the Administrator, however she was not available for interview. Review of facility policy titled Care Plan Guidelines, Revised 05/06/2016, revealed, 1. Meetings will be conducted within 21 days of admission, 2. The meetings will be scheduled by the Social Worker, and 3. The Social Worker will send out invitation letters to the resident, family member, responsible party.		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident was informed before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, which included charges for services not covered under Medicare/Medicaid or by the facility's per diem rate for 2 of 3 residents (Residents #15 and #19) reviewed for Medicare/Medicaid coverage. 1. The facility failed to ensure Resident #15 was given a NOMNC (is a notice that indicates when your care is set to end from a skilled nursing facility when discharged from skilled services prior to his covered days being exhausted. 2. The facility failed to ensure Resident #19 was given a SNF ABN when discharged from skilled services at the facility prior to covered days being exhausted. These failures could place residents at risk of not being aware of changes to services provided. Findings include: 1. Record review of Resident #15's face sheet, dated 12/10/25, reflected Resident #15 was a [AGE] year-old male, originally admitted to the facility on [DATE] with a diagnosis which included transient cerebral ischemic attack (stroke). Record review of Resident #15's quarterly MDS assessment, dated 11/26/25, reflected Resident #15 made himself understood and understood others. Resident #15's BIMS score was 15, which indicated his cognition was intact. Record review of Resident #15's SNF Beneficiary Notification Review reflected Resident #15 received Medicare Part A skilled services on 07/20/25, and the last covered day of Part A services was 08/15/25. The facility/provider initiated the discharge from Medicare Part A services when benefits were not exhausted. It was reflected that a NOMNC was not completed which would have informed Resident #15 about the termination, including the reason and his right to appeal the decision. 2. Record review of Resident #19's face sheet, dated 12/10/25, reflected Resident #19 was an [AGE] year-old female, admitted to the facility on [DATE] with a diagnosis which included Alzheimer's (progressive disease that destroys memory and other important mental functions). Record review of Resident #19's quarterly MDS assessment, dated 10/13/25, reflected Resident #19 usually made herself understood and usually understood others. Resident #19's BIMS score was 8, which indicated her cognition was moderately impaired. Record review of Resident #19's SNF Beneficiary Protection Notification Review indicated Resident #19 was receiving Medicare Part A services starting on 10/07/25, and the last day covered of Part A services was 10/13/25. It was reflected that a SNF ABN was not completed, which would have informed Resident #19 of the option to continue services at the risk of out-of-pocket. During an interview on 12/10/25 at 8:59 a.m., the MDS Coordinator stated she was responsible for ensuring Resident #19 was issued a SNF ABN. The MDS Coordinator stated Resident #19 had 93 skilled benefit days remaining. The MDS Coordinator stated she was unaware a SNF ABN and NOMNC should be issued. The MDS Coordinator stated the previous MDS Coordinator would have been responsible for ensuring Resident #15 was issued a NOMNC. The MDS Coordinator stated Resident #15 had 73 skilled benefit days remaining. The MDS Coordinator stated the form should have been issued if the resident had skilled benefit days remaining and was being discharged from Part A services and continued in the facility. The MDS Coordinator stated the Regional Operations Director was responsible for monitoring and overseeing. The MDS Coordinator stated it was important for the residents to receive the form so they would know how many days they had left and what they were responsible for. An attempted telephone interview on 12/10/25 at 5:00 p.m., with the Regional Operations Director was unsuccessful. During an interview on 12/10/25 at 6:54 p.m., the DON stated she expected the SNF ABN and NOMNC to be given when the resident had skilled benefit days remaining and was being discharged from Part A services and continued in the facility. The DON stated it was important for the residents to receive the forms to inform them about their care. An attempted telephone interview on 12/10/25 at 7:30 p.m., with the Administrator was unsuccessful. Record review of the facility's policy titled Beneficiary Notices of Non-Coverage revised 05/30/2018 indicated. it is the intent of named company to abide by the (continued on next page)		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Federal regulations that pertain to issuance of Advanced Notification of Non Coverage when it is believed that Medicare will not pay for services or items not meeting the criteria for skilled care that is no longer reasonable or necessary, or is considered custodial care. the purpose of this guide is to ensure that the correct form(s) for each situation are delivered in timely manner. SNFABN (1) Beneficiary drops to a non-skilled of care and benefits have not exhausted and remains in the facility. Notice of Medicare Non-coverage (1) Beneficiary drops to a non-skilled of care and benefits have not exhausted and remains in the facility.		

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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, interviews and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives and time frames to meet a resident's mental, nursing, and psychosocial needs that were identified in the comprehensive assessment for 1 of 6 residents (Resident #1) reviewed for care plans. The facility failed to fully develop a comprehensive person-centered care plan that was specific for Resident #1 to address the resident's communication deficit. This failure could place residents at risk for not getting their medical, physical, and psychosocial needs met and not being provided with the necessary care or services and having personalized plans developed to address their specific needs. The findings were: Record review of Resident #1's face sheet dated 12/10/2025 revealed a [AGE] year-old female originally admitted [DATE] and readmitted [DATE] with diagnoses including aphasia (difficult speaking), slurred speech, legal blindness, cerebral infarction (occurs when a blood clot blocks an artery in the brain, cutting off oxygen and nutrients leading to brain tissue death) with right sided weakness, and hypertension (high blood pressure). Record review of Resident #1's comprehensive MDS dated [DATE] revealed a BIMS Score of 9 indicating moderate cognitive impairment, had unclear speech, was sometimes understood and understands others. Further review of Resident #1's comprehensive MDS assessment dated [DATE] revealed Resident #1 presented with upper and lower extremity range of motion impairment, was bedfast (did not get out of bed during assessment period), and was totally dependent in all activities of daily living to include eating, dressing, toileting, bathing, transfers and mobility. Record review of Resident #1's comprehensive care plan with target completion date 11/07/2025 revealed there was not a care plan addressing the resident's communication deficit. During an interview and observation of Resident #1 on 12/08/2025 at 2:05 p.m. and on 12/09/2025 at 12:01 p.m., Resident #1 responded to surveyor questions with head nods and facial expressions only, with no attempt at verbal communication. During an interview on 12/09/2025 at 9:58 a.m., CNA A stated that Resident #1 does not speak and will use head nods to communicate her needs. During an interview on 12/10/2025 the Social Worker stated that she does feel Resident #1 has a communication problem and will use head nods, hand gestures and facial expressions to communicate. The Social Worker stated that she is responsible for completing the communication section of the MDS, but that the MDS Nurse is responsible for completing the care plan focus problems based off the Care Area Assessment Summary. The Social Worker stated that the risks for not identifying communication deficits on the care plan could mean the resident's needs are not being met. During an interview on 12/10/2025 at 3:00 p.m., the MDS Nurse stated that Resident #1's last care plan review was completed 11/12/2025 and the Interdisciplinary Team members did not catch that communication was not identified in the plan of care. The MDS Nurse stated that failure to identify communication deficits in the plan of care could result in the resident's needs not being met if the staff do not know how to communicate properly with her. During an interview on 12/10/2025 at 6:54 p.m., the DON stated that the care plan for Resident #1 should have included a communication focus problem with appropriate interventions specific to this resident. The DON stated she expects the Interdisciplinary Team members to accurately complete a plan of care reflecting the resident needs. The DON stated that she is ultimately responsible for the accuracy and completeness of the care plans. An interview was attempted on 12/10/25 at 7:31 p.m. with the Administrator, however she was not available for interview. Record review of the facility policy titled Comprehensive Care Plans, Revised 09/04/2024, revealed it is the policy of this facility 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 needs that are identified in the resident's comprehensive assessment.		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish based on the comprehensive assessment and consistent with the resident's needs and choices for 1 of 2 residents (Resident #48) reviewed for activities of daily living. The facility failed to provide communication assistance to effectively communicate with staff for Resident #48. This failure could place residents at risk for decline and diminished quality of life. Findings included: Record review of Resident #48's face sheet dated 12/10/25 indicated he was a [AGE] year-old male who admitted to the facility on [DATE] with the diagnoses Down syndrome (genetic condition leading to developmental delays), epilepsy (neurological condition marked by recurrent seizures), and cognitive communication deficit (struggle in communication due to cognitive problems). Record review of Resident #48's admission MDS dated [DATE] indicated he usually understood others and could usually make himself understood. The MDS also indicated he had a BIMS score of 99 because he was unable to complete the assessment and he had moderately impaired cognition. The MDS also indicated Resident #48 required set up assistance with eating, maximal assistance with bathing, supervision with toileting and transfers, and was independent with bed mobility. Record review of Resident #48's care plan dated 10/28/25 indicated Resident has a communication deficit: nonverbal status related to severe intellectual disabilities with interventions to Ensure availability and functioning of adaptive communication equipment: Communication/Message Board. Record review of the facility's undated document titled Communication with non-oral communication devices or sign language indicated Resident #48 required a communication board for communication. During an observation and interview on 12/08/25 at 3:05 PM Resident #48 was lying in bed and slightly smiled when asked questions but did not respond to surveyor. There was no communication tools noted, and roommate was unaware of any ever being used. During an observation and interview on 12/09/25 at 10:22 AM Resident #48 had no communication board in the room. Surveyor attempted to ask questions to Resident #48 but could not get Resident #48 to nod yes or no for any questions. During an observation and interview on 12/10/25 at 4:03 PM CNA N said Resident #48 was more hands on than verbal. CNA N said Resident #48 understood what the staff said, but he did not communicate back except for scrunching his nose. CNA N said Resident #48 had never had a communication board that she was aware of. CNA N said if Resident #48 had a communication board, it would have been in his bedside drawer. CNA N and surveyor looked in the bedside dresser drawers as well as bedside nightstand and no communication board was noted. CNA N said it would have been nice to have a communication board to tell if Resident #48 was hurting and where he was hurting or to know what type of food he really likes. During an interview on 12/10/25 at 4:14pm LVN D said she had never seen a communication board in Resident #48's room. If he had one, it would be located by the bed. LVN D said Resident #48 should have an order or a care plan if he was supposed to have one. LVN D showed the surveyor the care plan, and it was noted in the care plan that Resident #48 should have had a communication board as adaptive communication device. LVN D said no one had mentioned anything about a communication board to her. LVN D said she would speak with the DON and let her know right away so the facility could get a communication board in place. During an interview on 12/10/25 at 5:43 PM Resident #48's family member said she visits Resident #48 once a week and she felt like the staff did a good job taking care of him. She said she had never seen a communication board in Resident #48's room but she wished Resident #48 had a communication board. During an interview on 12/10/25 at 7:11 PM the DON said the facility ordered a communication board and it was in the facility especially for him prior to his admission on [DATE]. The DON said she was responsible as well as CNAs should have been responsible for ensuring the communication board was always available but no one ever notified her (continued on next page)		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the communication board being missing. The DON said the failure placed a risk for the resident not being able to communicate his needs. Record review of the facility undated policy Communication and Interpersonal Skills indicated:Communication- exchanging information with others. The process could be sent or received through verbal or by non-verbal means.Non-verbal communication is communicating without using words. Non-verbal can use behavior, body language, facial expressions, and attitudes or emotions. Example, resident pointing to a cup of water. The policy did not indicate use of a communication board.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to ensure residents maintained acceptable parameters of nutritional status and is offered sufficient fluid intake to maintain proper hydration and health for 2 of 5 residents (Resident #13 and Resident #19) reviewed for nutrition. 1. The facility failed to ensure Resident #13 had water in his cup to drink on 12/08/25 and 12/09/25. 2. The facility did not ensure Resident #19 was given a shake as ordered by the physician. This failure could place residents at risk for decreased nutritional status, decline in health, serious illness, or hospitalization. Findings included: 1. Record review of Resident #13's face sheet dated 12/10/25 indicated he was an [AGE] year-old male who admitted to the facility on [DATE] with the diagnoses diabetes mellitus (condition that causes the blood sugar to be elevated), chronic obstructive pulmonary disease (lung disease that blocks airflow and makes it difficult to breathe), obstructive and reflux uropathy (a blockage of urine flow, causing backup and kidney damage, pain, and infection), and muscle weakness. Record review of Resident #13's admission MDS assessment dated [DATE] indicated he understood others and was able to make himself understood. The MDS also indicated he had a BIMS score of 11 which meant he had moderate cognitive impairment. The MDS also indicated he was dependent on staff for toileting and bathing, he required moderate assistance with bed mobility and required set-up assistance with eating. The MDS also indicated he was on a mechanically altered diet that required change in texture of food or liquids. Record review of Resident #13's care plan revised on 12/05/25 indicated Resident #13 was on a no restrictions, mechanical soft, and with nectar thickened liquids diet with a goal to maintain adequate hydration and interventions to provide nectar thickened liquids as ordered. Record review of Resident #13's order summary report dated 12/10/25 indicated he had orders for: 1) Restrictions diet Mechanical Soft texture, Mildly Thick-Nectar consistency with a start date of 12/03/25 and no end date. 2) This resident is at risk for malnutrition due to sepsis (medical emergency related to the body response to a severe infection) with a start date of 11/25/25 and no end date. During an observation and interview on 12/08/25 at 11:35 AM Resident #13 was sitting up in his wheelchair visiting with a family member and had no water in his room. He said the facility made axle grease (which was what he called thickened liquids) but they did not leave any in the room for him to drink. Resident #13 said he never had water except on his food trays and he was worried because he had a urinary tract infection while in the hospital. Resident #13 said he was not offered fluids any other times. During an observation on 12/09/25 at 10:38 AM the physical therapist was in Resident #13's room working with him, but he continued to have no water in his room to drink. During an observation on 12/10/25 at 8:38 AM Resident #13 was out of his room but he did not have any water at his bedside. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Clarksville Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 300 E Baker St Clarksville, TX 75426	
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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/10/2025 at 11:33 AM CNA H said the dining room sends out fluids with their meals, and the nurse gives them fluids with their medications. She said she was told that they cannot leave thickening fluids in their room. She said if Resident #13 asked for fluids in between those times, she would have to go to the nurse and ask her to give her some thickened fluids. She said she would ask him if he wanted a drink, and he would drink it. She said she felt they could stay hydrated on their own if fluids were left in the room. CNA H said the failure placed residents at risk for dehydration. During an interview on 12/10/2025 at 2:10 PM, LVN M said the dietary staff does not deliver the thickened liquids to them at snack times. She said today (12/10/25) was the first time she had seen them being delivered. During an interview on 12/10/25 at 7:14 PM the DON said it was not their policy to have the water at the bedside all the time because it could change consistency. The DON said the facility staff used to leave the thickened water at the bedside and the company changed it to where the staff were not supposed to leave it. The DON said the CNAs were supposed to bring out water for residents daily at 10:00 AM, 2:00 PM, and 8:00 PM for hydration. The DON said the failure placed Resident #13 at risk of not having water when he wants it, but he has not had an issue with dehydration. An attempted telephone interview on 12/10/25 at 7:30 p.m. with the Administrator was unsuccessful. Record review of the facility policy Hydration Fluid Maintenance dated October 2010 indicated: Anticipated Outcome 1. The facility will have a comprehensive program to provide adequate opportunity for fluid intake to each resident. Risk factors for a resident becoming dehydrated are: ^ Coma/decreased sensorium (sensory apparatus) ^ Fluid loss and increased fluid needs (e.g., diarrhea, fever, uncontrolled diabetes) ^ Fluid Restriction ^ Functional impairment that makes it difficult to drink, reach fluid or communicate fluid needs.10. There will be no water pitcher at bedside for residents who have ordered Fluid Restrictions, Thickened liquids and NPO. For residents, on thickened liquids containers of pre-thickened liquids may be kept at bedside in a resident's personal refrigerator or a small cooler. 2. Record review of Resident #19's face sheet, dated 12/10/25, reflected Resident #19 was an [AGE] year-old female, admitted to the facility on [DATE] with a diagnosis which included Alzheimer's (progressive disease that destroys memory and other important mental functions). Record review of Resident #19's order summary report, dated 12/10/25, reflected ensure two times a day for supplement with a start date 10/24/25. Record review of Resident #19's quarterly MDS assessment, dated 10/13/25, reflected Resident #19 usually made herself understood and usually understood others. Resident #19's BIMS score was 8, which indicated her cognition was moderately impaired. Resident #19 was independent with eating. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #19 has not had 5% weight loss or more in the last month or loss of 10% or more in the last 6 months. Record review of Resident #19's comprehensive care plan, revised on 11/18/25, reflected Resident #19 was at risk for nutritional and hydration related to Alzheimer's, dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life), BIMS score, and recent acute illness. The care plan interventions included: provide, serve diet as ordered, and provide ensure as ordered. During an observation, interview and record review on 12/08/25 at 12:25 p.m., Resident #19 did not receive a shake with her lunch meal. The meal ticket reflected 4 oz of a nutritious shake. Resident #19 stated she was supposed to get a milk shake with her meals. During an interview on 12/08/25 at 3:02 p.m., CNA E stated the nurse must check the trays prior to passing them out to the residents to make sure the residents received the right diet. CNA E stated the DON had stepped away and the dietary staff stated it was ok to take the tray to Resident #19. CNA E stated it was important for residents to receive their milk shake to prevent weight loss. During an interview on 12/09/25 at 12:51 p.m., Dietary Aide F stated she was responsible for ensuring the milkshake was on the tray prior delivering to the residents. When asked why she did not ensure a milkshake was placed on a tray, Dietary Aide F stated, it was a mistake. Dietary Aide F stated it was important for residents to receive their milk shake to prevent weight loss. During an interview on 12/10/25 at 6:08 p.m., the Dietary Manager stated the aide was responsible for ensuring the residents receive the milkshake. The Dietary Manager stated she monitored meals by watching meal service daily. The Dietary Manager stated there has not been any issues in the past 3 months regarding residents not receiving the correct diet. The Dietary Manager stated it is important to ensure the residents were on the correct diet to prevent weight loss. During an interview on 12/10/25 at 6:54 p.m., the DON stated she expected the physician diet order to be followed. The DON stated she did not check Resident #19's tray prior to CNA E giving it to her. The DON stated the CNA E should have waited on her to come back before delivering the tray. The DON stated she monitored by weekly and random dining room rounds to ensure diet orders were followed. The DON stated there have been issues in the past, but staff were immediately in-serviced verbally. The DON stated it was important to receive the correct diet to give extra nutrition. An attempted telephone interview on 12/10/25 at 7:30 p.m., with the Administrator was unsuccessful. Record review of the facility's policy titled Menu Planning Guidelines and Procedure revised 07/12/24 indicated. Menus will be followed and served as written.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure that residents were free of significant medication errors for 1 of 1 resident (Resident #15) reviewed for insulin administration. The facility did not ensure LVN K administered Resident #15's Novolog (insulin medication) according to the manufacturer's instructions on 12/08/25. This failure could place residents at risk of medical complications and prevent them from receiving the therapeutic effects of their medications. Findings included: Record review of Resident #15's face sheet, dated 12/10/25, reflected Resident #15 was a [AGE] year-old male, admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included Type 2 diabetes mellitus (lifelong condition where the pancreas makes little or no insulin, which leads to high blood sugar levels), stroke, and high blood pressure Record review of Resident #15's quarterly MDS assessment, dated 11/26/25, indicated Resident #15 made himself understood and understood others. Resident #15's BIMS score was 15, which indicated his cognition was intact. The MDS indicated he received insulin over the 7-day look-back period. Record review of Resident #15's comprehensive care plan dated 08/16/23 indicated Resident #15 had diabetes mellitus. The care plan interventions were for staff to check his blood sugars, give diabetes medication as ordered, observe for adverse side effects and/or complications such as hypoglycemia. Record review of the physician order summary report, dated 10/23/25, reflected Resident #15 had an order for -NovoLog Flex Pen Subcutaneous Solution Pen injector 100 units per milliliter (Insulin Aspart) Inject 20 units subcutaneously before meals for diabetes. -NovoLog Flex Pen Subcutaneous Solution Pen injector 100 units per milliliter (Insulin Aspart) Inject as per sliding scale: if 200 - 250 = 2 units; 251 - 300 = 4 units; 301 - 350 = 6 units; 351 - 400 = 8 units; 401 - 450 = 10 units if over 400, contact primary physicians. Subcutaneously before meals and at bedtime, related to diabetes. During an observation and interview on 12/08/25 at 10:53 a.m., LVN K took Resident #15's blood sugar with a reading of 292. LVN K prepared Resident #15's Novolog by removing the pen cap, placing a needle onto the pen, and turning the dose knob to 24 units. LVN K administered the medication to Resident #15's right arm. LVN K did not prime (removing the air from the needle and cartridge) the insulin pen by turning the dose knob to 2 units before turning the dose knob to 24 units. LVN K said she was unaware she needed to prime the insulin before administering Resident #15's insulin. LVN K said after being questioned that she could see the importance of priming the insulin pen to ensure the resident received the correct dosage of insulin, which could have led to uncontrolled diabetes. During an interview on 12/10/25 at 7:00 p.m., the DON said she expected the nurse to take the resident's blood sugar and give the ordered dose of insulin. The DON said she did not know right off hand what the policy said on the administration of the insulin pen. The DON said she was unaware that the insulin pen needed to be primed before administering the insulin dose. She said she did a random medication pass, which included insulin administration, and she did not notice any issues. After reviewing the manufacturer's package insert, the DON said it was important to properly prime the insulin pen to prevent blood sugar issues. She said she would do an in-service on the proper way to prime the insulin pens. During an attempted phone interview on 12/10/25 at 7:30 p.m. with the Administrator was unsuccessful. Record review of the undated facility's Licensed Nurse Skills Review indicated #1 Perform hand hygiene, #2 Check the physician's order for insulin, #5 Prepare injection: attach the needle, remove the needle cap, check the flow of delivery (air shot) with a 2 unit prime every time and then select the dosage. Record review of the manufacturer's insert titled Insulin Aspart Recombinant Novolog, indicated that insulin is a fast-acting type of insulin. Insulin is one of many hormones that help the body turn the food we eat into energy. To use the flex pen or flex touch pen: #1 wash your hands, #2 primed the pen by removing the air from the needle and cartridge, Select 2 units when turning the dose knob, #3 hold the pen with the needle pointing up then gently tap the cartridge holder to collect the air bubbles at the top, #4 press the push button until it stops you should see a zero in (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the dose window, #5 you should see insulin at the needle tip if you do not see anything repeat the priming steps but not more than six times if there is still no answer do not use the pen.#6 turn the dose selector, be careful not to press the button #7 insert the needle into your skin and press the push button all the way in for at least 6 seconds. Keep pressing until the needle has pulled out from the skin. This will make sure that you have received the full dose.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to ensure all drugs were stored in a locked compartment, only accessible by authorized personnel, and labeled and dated correctly for 1 of 25 residents (Resident #11) observed for medication storage. 1. The facility failed to ensure Resident #11 did not have hydrocortisone cream and Neosporin on his bedside table and dresser. These failures could place residents at risk for not receiving drugs and biologicals as needed, or overmedicating. Findings include: Record review of Resident #11's face sheet dated 12/10/25 indicated he was a [AGE] year-old male who re-admitted to the facility on [DATE] with the diagnoses PTSD (post-traumatic stress disorder), Dementia (cognitive decline that effects daily life caused by brain cell damage), major depressive disorder (persistent sadness, loss of interest, fatigue, and change in sleep/appetite), diabetes mellitus (chronic metabolism condition marked by high blood sugars), and presbyopia (natural age-related loss of eye's ability to focus on nearby objects). Record review of Resident #11's quarterly MDS dated [DATE] indicated he could make himself understood and was able to understand others. The MDS also indicated he had a BIMS score of 15 which meant his cognition was intact. The MDS also indicated he was independent with all ADLs. Record review of Resident #11's care plan dated 09/20/25 indicated he had impaired cognition and was at risk for a further decline in cognitive and functional abilities related to Parkinsons with interventions to administer medications per physician orders and monitor. Record review of Resident #11's order summary report dated 12/10/25 indicated:Hydrocortisone External Cream 1 % (Hydrocortisone (Topical)) Apply to affected area topically every 12 hours as needed for itching apply thin layer to affected area with a start date of 10/30/2024 and no end date. The order summary report did not indicate an order for Neosporin. During an observation and interview on 12/09/2025 at 10:26 AM, Resident #11 had hydrocortisone cream 1% on his bedside table. Resident #11 said he used the hydrocortisone cream for places on his arm when he scratches, he said one of the nurses gave it to him. During an observation on 12/10/2025 at 8:42 AM, Resident #11 was out of the room and had hydrocortisone 1% cream in his room on his nightstand. During an interview on 12/10/2025 at 3:58 PM, LVN M said the facility did not have an order for anyone who kept medications at bedside. LVN M said Resident #11 should not have the hydrocortisone medication at his bedside. LVN M said the failure placed a risk for Resident #11 or any other resident getting the medication, eating it, using too much of the medication, getting the medication in their eyes, or putting the medication in the wrong place. LVN M said all the staff was responsible for ensuring there was no medications in the residents' room. During an interview on 12/10/2025 at 7:08 PM, the DON said she found the hydrocortisone 1% cream and a tube of Neosporin cream in Resident #11's room when she went to clean it out. The DON said Resident #11 had been told over and over that he could not have medications in his room. She said she expected the medications to be stored in the medication cart or the medication rooms. The DON said the staff make rounds daily and all staff was responsible for ensuring the medications was not in Resident #11's room. The DON said the failure placed a risk to having other residents coming in Resident #11's room and ingest it or Resident #11 could have taken or used too much. An attempted telephone interview on 12/10/25 at 7:30 p.m., with the Administrator was unsuccessful. Record review of the facility policy Medication Storage dated 1/20/21 indicated: Policy: It is the policy of this facility to ensure all medications housed on our premises will be stored, dated and labeled according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security.Policy Explanation and Compliance Guidelines 1. General Guidelines: a. All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls.		

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals for 1 of 5 (Resident #19) residents reviewed for special eating equipment and assistance when consuming meals. The facility failed to ensure Resident #19 had a physician's ordered cup with lid for drinking fluids. This failure could place residents at risk for harm by weight loss, diminished independence, and self-esteem. Findings included: Record review of Resident #19's face sheet, dated 12/10/25, reflected Resident #19 was an [AGE] year-old female, admitted to the facility on [DATE] with a diagnosis which included Alzheimer's (progressive disease that destroys memory and other important mental functions). Record review of Resident #19's order summary report, dated 12/10/25, reflected regular texture, thin consistency, fortified foods, and cup with lid and straws with every meal with a start date 10/07/25. Record review of Resident #19's quarterly MDS assessment, dated 10/13/25, reflected Resident #19's usually made herself understood and usually understood others. Resident #19's BIMS score was 8, which indicated her cognition was moderately impaired. Resident #19 was independent with eating. Resident #19 has not had 5% weight loss or more in the last month or loss of 10% or more in last 6 months. Record review of Resident #19's comprehensive care plan, revised on 11/18/25, reflected Resident #19 was at risk for nutritional and hydration related to Alzheimer's, dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life), BIMS score, and recent acute illness. The care plan interventions included: provide, serve diet as ordered, and provide ensure as ordered. During an observation and interview on 12/08/25 at 12:25 p.m., Resident #19 did not receive a lid with her cup. Resident #19 stated she did not know if she needed a lid or not. During an interview on 12/08/25 at 3:02 p.m., CNA E stated the nurse must check the trays prior to passing them out to the residents to make sure the residents received the right diet. CNA E stated the DON had stepped away and the dietary staff stated it was ok to take the tray to Resident #19. CNA E stated it was important for Resident #19 to receive a lid on her cup to prevent spillage. During an interview on 12/09/25 at 12:51 p.m., Dietary Aide F stated she was responsible for ensuring a lid was on the cup prior to delivering to Resident #19. When asked why she did not ensure a lid was on the cup, Dietary Aide F stated, it was a mistake. Dietary Aide F stated it was important for Resident #19 to receive a lid on her cup to prevent spillage. During an interview on 12/10/25 at 6:08 p.m., the Dietary Manager stated the aide was responsible for ensuring the residents receive a lip on their cup. The Dietary Manager stated she monitored meals by watching meal service daily. The Dietary Manager stated there has not been any issues in the past 3 months regarding residents not receiving the correct diet. The Dietary Manager stated it is important to ensure the residents receive a lid on the cup to prevent spillage which could cause a dignity issue. During an interview on 12/10/25 at 6:54 p.m., the DON stated she expected the physician diet order to be followed. The DON stated she did not check Resident #19's tray prior to CNA E giving it to her. The DON stated the CNA E should have waited on her to come back before delivering the tray. The DON stated she monitored by weekly and random dining room rounds to ensure diet orders were followed. The DON stated there have been issues in the past, but staff were immediately in-service verbally. The DON stated it was important to receive the correct diet to prevent spillage. An attempted telephone interview on 12/10/25 at 7:30 p.m., with the Administrator was unsuccessful. Record review of the facility's policy titled Menu Planning Guidelines and Procedure revised 07/12/24 indicated. Menus will be followed and served as written.		

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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** Based on observations, interviews, and record reviews, 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 6 residents (Resident #13) room reviewed for infection control practices and enhanced barrier precautions. 1) The facility failed to ensure the Treatment nurse used the proper handwashing technique while providing wound care for Resident #13. 2) The facility failed to ensure the Treatment Nurse disinfected her scissors during wound care when she cut the dirty dressing and then cut the clean dressing with the contaminated scissors. These failures could place residents at increased risk for serious complications from a communicable disease that could diminish the residents' quality of life. Findings included: Record review of Resident #13's face sheet dated 12/10/25 indicated he was an [AGE] year-old male who admitted to the facility on [DATE] with the diagnoses diabetes mellitus (condition that causes the blood sugar to be elevated), chronic obstructive pulmonary disease (lung disease that blocks airflow and makes it difficult to breathe), obstructive and reflux uropathy (a blockage of urine flow, causing backup and kidney damage, pain, and infection), and muscle weakness. Record review of Resident #13's admission MDS assessment dated [DATE] indicated he understood others and was able to make himself understood. The MDS also indicated he had a BIMS score of 11 which meant he had moderate cognitive impairment. The MDS also indicated he was dependent on staff for toileting and bathing, he required moderate assistance with bed mobility and required set-up assistance with eating. Record review of Resident #13's care plan dated 11/26/25 indicated he had a pressure ulcer and was at risk for infection, pain, and a decline in functional abilities with a goal to be free from infection and interventions to provide wound care per physician's order and keep dressing clean, dry, and intact. During an observation on 12/10/2025 at 3:15 PM the Treatment Nurse provided wound care to Resident #13's right heel. The Treatment nurse performed the wound care using aseptic technique. Prior to initiating wound care the Treatment Nurse performed hand hygiene using the sink in Resident #13's bathroom. When the Treatment Nurse turned off the water faucet, she used her bare hand/wrist. The Treatment Nurse was also observed between glove changes turning the faucet off with her bare hand/wrist and again at the completion of wound care prior to exiting the room the Treatment Nurse turned the water faucet off using her bare hand/wrist. During the wound care procedure the Treatment Nurse cleaned her scissors prior to the start of the procedure, but removed the soiled dressing from the patient's right heel using scissors, placed the dirty scissors back on the clean surface, and failed to clean or disinfect the scissors prior to being used to cut clean dressings before the clean dressings were applied to the open wound. During an interview on 12/10/25 at 3:52 PM the treatment Nurse said she felt as though she washed her hands excessively and she usually used the hand sanitizer in between glove changes. The Treatment Nurse said she should have turned the water off with her paper towel instead of her hand because she was re-contaminating her hands. The Treatment Nurse said she also failed to clean the scissors after she cut the dirty dressing off and before cutting the clean dressing. The Treatment Nurse said the failure placed a risk for recontamination or infection. During an interview on 12/10/2025 at 7:17 PM DON said her expectation was for the treatment nurse to use a paper towel to turn the water off and clean scissors between clean and dirty surfaces. The failure placed a risk for infection. An attempted telephone interview on 12/10/25 at 7:30 p.m. with the Administrator was unsuccessful. Record review of the facility policy Hand Hygiene dated 2/20/22 indicated: Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. 5. Hand hygiene technique when using soap and water: a. Wet hands with water. Avoid using hot water to prevent drying of skin. e. Dry thoroughly with a single-use towel f. Use clean towel to turn off the faucet. Record review (continued on next page)		

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the facility policy Cleaning and Disinfecting Portable Equipment dated 5/4/21 indicated: Anticipated Outcome: It is the policy of this facility to follow infection control principles to prevent spread of infection through contact with portable equipment in the resident's care environment.2. Staff shall follow environmental infection control principles for cleaning and disinfecting the equipment.a. Each user is responsible for routine cleaning and disinfection. b. Cleaning shall be performed daily and between residents. c. Hard surfaces shall be cleaned with a cloth dampened with an approved cleaner/disinfectant (spray the cloth not the device) or a disposable pre-moistened cloth. Allow surfaces to air dry before reuse. (Follow manufacturer's instructions when selecting cleaning/disinfection products.).		