STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675038	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clyde Nursing Center	806 Stephens St Clyde, TX 79510

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the resident's had the right to reside and receive services in the facility with accommodation of residents' needs and preferences except when to do so would endanger the health or safety of the resident or other residents for 3 of 12 residents(Resident #36, Resident #14, and Resident #32) reviewed for resident rights. The facility failed to ensure Resident #36, Resident #14, and Resident #32's call lights were within reach. This failure could place residents at risk of a diminished quality of life and lead to a loss of self-esteem and isolation.Findings include: 1. Record review of Resident #36's electronic face sheet, accessed 06/10/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #36 had diagnoses which included Cerebral Infarction (a stroke caused by blockage in the blood vessel that supplies the brain) and depression. Record review of Resident #36's quarterly MDS assessment, dated 05/27/2026, reflected Resident #36 had a BIMS score of 10, which indicated moderate cognitive impairment. Record review of Resident #36's comprehensive care plan, last revised on 06/08/2026, reflected Resident #10 had impaired vision, communication problem, and potential for falls with intervention of Keep call light in reach in room and bathroom. During an observation on 06/08/2026 at 11:00 AM, revealed Resident #36 was hollering out into the hallway from her bed. The call light was in between the side rail and mattress. Staff assisted the resident but did not move the call light. During an observation and interview on 06/09/2026 at 10:18 AM, revealed Resident #36 was asleep in bed. The call light was stuck between the side rail and mattress. Resident #36 stated her call light was always tied to the bedrail, and she could never find it. She stated she just hollered out when she needed help. 2. Record review of Resident #14's electronic face sheet, accessed 06/10/2026, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #14 had diagnoses which included dementia, anxiety, and depression. Record review of Resident #14's significant change MDS assessment, dated 05/13/2026, reflected Resident #14 had a BIMS score of 00, which indicated severe cognitive impairment. Record review of Resident #14's comprehensive care plan, last revised on 06/08/2026, reflected Resident #10 had impaired vision, communication problem, and exhibits verbally aggressive behaviors and is at risk of not having her needs met in a timely manner with intervention of Keep call light in reach in room and bathroom. During an observation on 06/08/2026 at 11:00 AM, revealed Resident #14 was asleep in bed. A soft touch-call light was hanging behind the bed at the top of the alarm box out of resident's reach. Resident #14 unable to answer questions. During an observation on 06/09/2026 at 10:20 AM, revealed Resident #14 was asleep in bed. A soft touch-call light was hanging behind the bed at the top of the alarm box out of resident's reach. Resident #14 unable to answer questions. During an interview on 06/09/2026 at 10:30 AM, Resident #14's representative stated he expected the call light to be in reach. He stated it upset him that they did not always put it in reach. He stated Resident #36 had a soft touch call light and the staff got annoyed because it was very sensitive and it went off a lot. 3. Record review of Resident #32's electronic face sheet, accessed 06/10/2026, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #32 had diagnoses which included dementia, anxiety, and depression. Record review of Resident #32's significant change MDS (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assessment, dated 05/13/2026, reflected Resident #14 had a BIMS score of 00, which indicated severe cognitive impairment. Record review of Resident #32's comprehensive care plan, last revised on 06/08/2026, reflected Resident #10 had impaired vision, communication problem, and exhibits verbally aggressive behaviors and is at risk of not having her needs met in a timely manner with intervention of Keep call light in reach in room and bathroom. During an observation on 06/08/2026 at 11:00 AM, revealed Resident #32 was asleep in bed. The call light was stuck between the side rail and mattress. During an observation and interview on 06/09/2026 at 10:20 AM, revealed Resident #32 was asleep in bed. The call light was stuck between the side rail and mattress. Resident #32 stated she didn't know where her call light was. When pointed out the resident was unable to reach it due to the call light being tangled on the side rail and stuck between the mattress and bedrail. During an interview on 06/09/2026 at 4:06 PM, the DON stated his expectation was for residents call light to always be in reach. He stated residents should always be able to call for assistance. He stated not having the call light could lead to falls and residents not getting their needs met. He stated he rounded periodically to ensure that call lights were within reach. During an interview on 06/10/2026 at 2:04 PM, CNA A stated every time she left a resident room, she ensured all safety devices were in place, and the call light was in reach. She stated in reach meant the resident could see it and reach it. She stated residents could not get the help they needed if they could not reach their call light. During an interview on 06/10/2026 at 4:18 PM, the Administrator stated his expectation was for call lights to be within reach and within sight at all times. He stated residents could fall and not get their needs met. He stated he randomly made rounds in the facility to ensure call light placement. Record review of the facility's policy titled Call Light Response, dated 02/10/2021, reflected Process.with each interaction in the resident's room or bathroom, staff will ensure the call light is within reach of resident and secured, as needed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the resident had a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely for 3 of 24 (room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER]) resident rooms and 1 of 1 handicap resident restroom reviewed for resident rights and environmental concerns.1. The facility failed to have water above 100 ˆF in the restroom sink of resident room [ROOM NUMBER] on 06/08/2026.2. The facility failed to have water above 100 ˆF in the handicap restroom sink located on hall 3 on 06/08/2026.3. The facility failed to have water above 100 ˆF in the adjoining restroom for resident room [ROOM NUMBER] and resident room [ROOM NUMBER] on 06/09/2026.These failures could place residents at risk of being uncomfortable and infections from living in an environment that did not function.Findings included:1. Record review of Resident #1's electronic face sheet, dated 06/10/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had a diagnosis which included bacteriuria (bacteria in urine) that was developed during stay. Record review of Resident #1's quarterly MDS assessment, dated 04/01/2026, reflected she had a BIMS score of 12, which indicated moderate cognitive impairment. Resident #1 required supervision with personal hygiene which included washing hands and substantial assistance with toileting hygiene.Record review of Resident #1's comprehensive care plan, dated 05/28/2026, reflected Resident #1 had a UTI with interventions which included resident / caregiver teaching should include good hygiene practices such as females to wipe and cleanse from front to back and clean perineum (region between the genitals and the anus) area well after BM in order to help prevent bacteria in urinary tract.During an observation on 06/09/2026 at 10:20 a.m., there was an adjoining restroom between room [ROOM NUMBER] and room [ROOM NUMBER]. The temperature of the hot water in the restroom sink was 95.5 ˆF using state issued thermometer after the hot water was ran for over one minute. During an interview on 06/10/2026 at 3:23 p.m., Resident #1 stated she would like the water in the bathroom to be hotter. She stated the water had only been warm in the restroom ever since she had resided in the facility. 2. Record review of Resident #40's electronic face sheet, dated 06/11/2026, reflected a [AGE] year-old female who was admitted originally to the facility on [DATE] and readmitted on [DATE]. Resident #40 had a diagnosis which included dementia (loss of memory, thinking, and reasoning skills).Record review of Resident #40's quarterly MDS assessment, dated 04/20/2026, reflected she had a BIMS score of 05, which indicated severe cognitive impairment. Resident #40 needed setup assistance for toileting hygiene and needed supervision assistance for personal hygiene which included washing hands.During an observation on 06/08/2026 at 11:25 a.m., Resident #40 was in room [ROOM NUMBER] lying in the bed next to the window. The restroom connected to room [ROOM NUMBER] had a sink beside the toilet. The hot water in the restroom sink was cool to the touch after letting it run for approximately one minute. During an observation on 06/08/2026 at 4:09 p.m., revealed Resident room [ROOM NUMBER] bathroom sink hot water temperature was 74 ˆF using state issued thermometer after letting it run for over five minutes. During a telephone interview on 06/08/2026 at 2:56 p.m., Resident #40's family member stated she was concerned residents, which included Resident #40, did not have access to hot water, only cold water. Resident #40's family member stated there was not a problem with the water heater in the facility, but the problem was the setting the facility had made for all residents. Resident #40's family member did not state how they knew there was not a problem with the water heater in the facility. During an observation on 06/09/2026 at 4:17 p.m., revealed the Hall 3 handicap residents' restroom sink hot water was cool to the touch. The temperature of the sink's hot water was 88 ˆF using state issued thermometer after letting the hot water run for over one minute. During an interview on 06/10/2026 at 10:55 a.m., the Maint. Director stated the facility had 2 water heaters (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	located on Hall 1 in the facility. He stated during the day the CNAs performed showers, the end of the other two halls resident rooms would not be hot at times. He stated he would rather error on the cool side and not have the water scalding in the resident rooms to prevent burns to the residents. He stated he had difficulty keeping the water warm and had the mixing valve replaced in the past. He stated the mixing valve helped adjust the water temperatures. He stated the facility could not have water above 110 ˆF in the resident rooms per regulations but did not state a level the temperature needed to stay above. He stated he would not mind the water in the sink in the room not being hot if he was a resident in the facility. He stated the CNAs performed showers daily during the week starting at 6 a.m. and kept going until 2 p.m. He stated when he checked the temperatures, and adjusted the water temperatures, he did before or after the showers were completed to get temperatures above 100 ˆF. He stated he did not have any complaints from residents that the water temperature in the rooms was not hot enough. He stated he did not think the residents had any negative effect from the water temperatures being lower than 100 ˆF certain times of the dayDuring an interview on 06/10/2026 at 11:11 a.m., the DON stated a normal person would want hot water in the sink of a bathroom they used to wash their hands. He stated he was not aware of any residents or their representative complaining about water temperatures in the past. He stated the Maint. Director was responsible for ensuring water temperatures were comfortable for the residents. He stated the facility did not have any increased infection spread recently and he kept an infection control tracking system. He stated not having hot water could cause discomfort and was not causing infection spread.During an interview on 06/10/2026 at 11:38 a.m., the ADMN stated he expected for the residents to have access to hot water within the state guidelines of 100 ˆF to 110 ˆF. He stated he was not aware of the Maint. Director was taking weekly temperatures and logging them outside of the residents' shower schedules until today. He stated a reasonable person would want water in their rooms above 95 ˆF in the restroom sink. He stated the facility did not have an attic and the water pipes came out of the water heater room, ran down the halls in pipes, and that could cause the temperature to fluctuate. He stated the facility had a flat roof that did not allow there to be an attic. He stated not having hot water could cause an uncomfortable environment. He stated he had not received any complaints from residents or their representatives about water temperature. Record review of the facility's maintenance care log reflected between 04/13/2026 - 06/03/2026 weekly hot water temperatures documented the hot water in multiple places in the facility including resident rooms was above 100 ˆF.Record review of facility's policy titled Resident Rights, dated 02/23/2026, reflected 8. Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the resident had the right to be informed of, and participate in his or her treatment, his or her treatment including the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or options he or she preferred for 1 of 2 residents (Resident #40) reviewed for resident rights. The facility failed to obtain a signed informed consent based on information of the benefits, risks, and options available for Resident #40's bed alarm and chair alarm prior to placing them on the wheelchair of Resident #40. This failure could place residents at risk of unnecessary restriction of their freedom of movement and diminished quality of life. Findings include: Record review of Resident # 40's face sheet, dated 06/09/2026, revealed a [AGE] year-old female who was most recently readmitted to the facility on [DATE]. Resident #40 had the following diagnoses listed: unspecified dementia with mood disturbance (a diagnosis given when a person experiences significant cognitive decline and noticeable emotional changes such as depression, apathy, or anxiety), repeated falls, muscle weakness, unsteadiness on feet, and osteoporosis (a medical condition in which the bones become brittle and fragile). She had a family member listed as her medical and financial power of attorney. Record review of Resident #40's quarterly MDS assessment, dated 03/20/2026, revealed a BIMS score of 05, which indicated she had severely impaired cognition. Resident #40 had one fall since her most recent readmission with no major injuries. The restraints and alarms section reflected, she had a bed alarm and a chair alarm. Record review of Resident # 40's care plan, last revised on 11/12/1015, revealed a focus of: Residents have the potential for falls related to cognitive impairment, Psychoactive drug use, Gait/balance problems, and Fall Risk Score >10 (high fall risk) Goal: The resident will be free of falls through the next review date.Interventions included:Educated by Administrator on using her Call Light. Pressure Sensitive Alarm to wheelchair, recliner, and bed to alert staff to unassisted transfers. Anticipate and meet the resident's needs. Place items frequently used by the resident within easy reach when in the room. Record review of Resident #40's fall risk assessment, dated 03/18/2026, revealed the following documentation: Resident #40 had a history of one to two falls in the last 6 months, she took hypoglycemic medication (to lower blood sugar) and narcotics, within the last 7 days, recalled three out of four of the following; current season, that she was in a nursing home, location of room, staff names/faces, was able to see adequately, was continent of bowel and bladder, had no agitated behavior in the last 7 days, she did not have a drop in blood pressure when lying and standing, and her gait was more unsteady. Based off these answers, it was determined the resident had a low fall risk. Record review of a grievance form, dated 05/25/2026, made by a family member of Resident # 40 on her behalf, stated the following: Family member states that the nurse LVN A always tells [Resident #40] to stay in her bed and she cannot be mobile in her room. The family member wants that nurse not to go back into [Resident #40's] room, and wants the bed alarm removed and Resident #40 to have her walker back in her room. The Facility followed up with two other family members and not the family member who filed the grievance. The follow up stated in part: Family members of the resident discussed the situation on 05/26/2026 with the administrator and the DON. They understand the interventions put into place to prevent falls such as bed alarms and redirecting the residents when necessary. They do not want the LVN A to do it in an unprofessional manner. Record review of the facility incident log since the last survey revealed Resident # 40's last fall was on 08/27/2025. Record review of Resident #40's active physician orders, dated 06/11/2026, revealed the following orders that were initiated on 03/18/2026: Alarm to bed to alert staff of attempts to transfer unassisted due to falls for a diagnosis of unspecified dementia with mood disturbance. Ensure proper placement and functioning. Every shift for resident safety. Alarm to wheelchair to alert staff of attempts to transfer unassisted due to falls for a diagnosis of unspecified (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dementia with mood disturbance. Record review of Resident # 40's EMR revealed there was no signed consent for a chair or a bed alarm on her chart. During an observation and interview on 06/08/2026 at 4:17 PM, revealed Resident # 40 had a bed alarm on her bed and she was standing up upon entrance to the room. She then turned around and sat back down on her bed. The bed alarm did not sound until she sat down. She stated the bed alarm bothered her when it made noise. During an observation of five videos on 06/09/2026 at 7:57 AM, provided by a family member, revealed Resident # 40 was in her room sitting on her bed. She would get up; the alarm would go off. LVN 1 would go into the resident's room and tell her to get back in her bed. This happened repeatedly. Resident #40 stated Why does that alarm go off? You go on and go to sleep! LVN A stated I can't, because you won't stay in bed she then turned around and left the room. During interview on 6/06/2026 at 4:20 PM, LVN 1 stated Resident #40 had several falls in the past but none recently. She stated she had the bed and chair alarm so she would not fall and possibly hurt herself. She stated the alarm did not restrict the residents movement. She stated the resident got up without assistance anyway. She stated she did not know of any plans to remove the alarm, and no one asked her to remove it. During an interview on 06/10/2026 at 8:30 AM, Resident #40's family member stated at one point Resident #40 was very weak and not eating, but that was several months ago. The family member stated Resident #40 barely moved, and the alarm went off. She stated she felt the alarm restricted Resident #40's movement because she was not allowed to get up and move freely about her room. She stated we want her up, using her walker and walking in her room. She stated she did not like the alarm use and she did not think the administrator would allow them to remove the alarm. She stated she did not remember if she was ever asked for consent before the alarm was placed on Resident # 40. She stated she was told by the Administrator it kept Resident # 40 from falling, and the administrator stated Resident # 40 needed to have therapy before the alarm could be removed. She stated when the administrator told her this, she thought the facility would not allow the alarm to be removed from Resident #40. During an interview on 06/11/2026 at 8:59 AM, the DON stated Resident #40's alarm did not fit the definition of a restraint because it did not prevent her from getting up, it just alerted the staff she needed assistance. He stated he did not think he needed a consent for a bed or chair alarm. He stated he saw a video provided to him by a family member of Resident # 40. During the video LVN 1 checked on Resident #40 and told her to get back in bed. He stated Resident #40 should not be told to get back in bed; she should be assisted or allowed to get up and move about her room with supervision. He stated LVN 1 was inserviced on Professionalism after the family made the grievance and showed him the video. During an interview with the facility administrator on 06/11/2026 at 10:00 AM, he stated he did not consider the bed or chair alarm a restraint. He stated it was an intervention to keep her from falling and it worked. He stated he advised the residents family member that the resident should receive therapy before they removed the alarm. He stated staff should not tell the resident to get back in her bed when the alarm went off. He stated he did not know the family members felt they didn't have a choice in Resident 40's care. He thought they were in agreement. He stated he did not think a consent was needed for the alarm, because it was not a restraint. Record review of the Resident Rights policy provided by the facility, dated 02/23/2016, read in part: The facility will inform the resident both orally and in writing in a language that the resident understands her rights in all rules governing resident conduct and responsibilities during the stay in the facility. Exercise of rights. The resident has the right to exercise his or her rights as a resident of this facility and as a citizen or resident of the United states the resident has the right to be informed and participate in his or her treatment Including the rock can be fully informed in language that he or she can understand of his or her total health status including but not limited to his or her medical condition. To be informed in advance of the character be furnished in the type of caregiver or professional that will furnish the care the right to request refunds and or discontinued treatment to participate in our refused to participate in experimental research and to formulate an advanced directive. Record review of the Sensory Alarm Policy, dated revised 08/06/1018 05/05, read in part It is the policy of this facility to utilize resident (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	alarms in limited circumstances and of coordinates with the residents needs goals and preferences of the resident will be to attain or maintain his or her highest practicable level of physical mental and psychosocial well-being. The use of alarms does not eliminate the need for adequate supervision of the resident identification and addressing resident needs if the alarm is triggered. And you lost for the safe and appropriate use of residential markets including efforts to identify risk evaluation and analyze risk implement interventions to reduce risk and monitor for effectiveness of the interventions and modifying interventions necessary. Considerations or discontinuation of alarms include but are not limited to the behavior symptoms or risk warranting the use of the alarms are no longer present, the risks associated with the use of the alarm outweigh the benefit, evidence of adverse consequences associated with the use of the alarm, and resident family goals and preferences change. There was no policy in regard to a signed consent for a bed or chair alarm.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment for one of 12 residents (Resident #2) reviewed for PASARR. The facility failed to correctly identify Resident #2 as having a mental illness and did not complete a new PASARR Level One Screening. This failure could place residents at risk of not receiving needed services and care.The findings were: Record review of Resident #2's face sheet, accessed 06/10/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2 had diagnoses on admission which included Psychotic Disorder with delusions and Major Depressive Disorder, with no diagnosis of dementia. Record review of Resident #2's quarterly MDS assessment, dated 04/15/2026, reflected Resident #2 had a BIMS score of 11, which indicated moderate cognitive impairment. Record review of Resident #2's Comprehensive Care Plan, dated 03/12/2026, reflected the resident had depression and anxiety, and resident used psychotropic drugs. Record review of Resident #2's PASARR Level One Screening Forms, dated 02/03/2025, reflected she did not have a primary diagnosis of dementia. It revealed she was negative for mental illness, intellectual disability, or developmental disability. The form had not been updated. During an interview on 06/10/2026 at 3:40 PM, the MDS coordinator stated the PASARR Level One Screening was completed by another facility prior to admission. She stated since the PASARR Level One Screening showed negative mental illness she did not pursue any further actions. She stated she did not know there were any further steps to be taken. During an interview on 06/10/2026 at 3:56 PM, the RCN stated once the facility learned Resident #2 had a mental illness diagnosis the facility should have completed a new PASARR Level One Screening and followed the steps accordingly. She stated the PASRR Level One Screening would have triggered Resident #2 to have a PASARR Level Two Screening evaluation to determine the need for PASARR services. Record review of the facility's policy titled Preadmission and Screening Resident [NAME] Rules, dated 04/26/2016, reflected Purpose: The purpose of this guideline is to direct the user through the PASRR procedures. Procedure: If negative.If the resident has a qualifying mental illness diagnosis and the nursing facility feels the resident should be positive, they should talk to the referring entity and ask them to correct the PASARR Level One Screening or complete the 1012.