STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676411	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clarendon Nursing Home	Ten Medical Center Dr Clarendon, TX 79226

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical service to include accurate dispensing and administering of biologicals for 1 of 3 medication storage areas reviewed to meet the needs of each resident. The facility had 8 inulin medications expired according to the date documented on the bottle/pen of when it was opened. This failure could result in ineffective treatment resulting in exacerbation of residents' disease processes.Findings included: During an observation on [DATE] at 11:08 AM (with LVN A present) of the facility's medication room noted there were 8 insulins that revealed the following:2-Humulog insulin bottles marked with an open/accessed date of [DATE]. (opened 29 days prior to today's date)1-Novolog insulin bottle marked with an open/accessed date of [DATE]. (opened 46 days prior to today's date)1-Lantus insulin bottle marked with an open/accessed date of [DATE]. (opened 33 days prior to today's date)1-Novolog insulin bottle marked with an open/accessed date of [DATE]. (opened 44 days prior to today's date)1-Humulog insulin pen was not marked with a date it was open/accessed. 1-Humulog insulin pen marked with an open/accessed date of [DATE]. (opened 41 days prior to today's date)1-Lantus insulin pen marked with an open/accessed date of [DATE]. (opened 33 days prior to today's date)LVN A verified all 8 insulins were currently being used for resident treatment. During an interview on [DATE] at 11:14 AM LVN A (the nurse responsible for this shift for administering all injectable medications to include insulin) verified all 8 insulins reviewed had expired. LVN A reported this was a problem and she would immediately dispose of all the expired insulins. LVN A reported the facility had an instruction sheet at the nurses' station containing information on all insulins of when they were to be disposed depending on the type every 28 or 30 days. LVN A reported if an insulin was given that was expired then the resident could have a reaction, or it would not be effective which would affect the residents' condition by raising their blood sugar. During an interview on [DATE] at 9:10 AM the DON reported all insulins should be marked when they are opened with the date they are opened and when they expire which was usually 28 days. The DON reported they have an instruction manual at the nurse's station that gives instructions on all their medications on how they are used and when they should expire to include their insulins. The DON reported she had contacted the Medical Director and the Pharmacy Consultant for additional information but had not heard anything at this time. The DON reported it was the facility policy that each nurse administering any medication was responsible for verifying the medication was viable to administer to include the insulin to include if it was expired. The DON reported that if a medication (especially insulin) was administered was expired then the potency was not what it should be, and the treatment would not be effective. Record review of the facility provided instruction guide titled Insulin Vials PharMerica 6/2021, revealed the following information: Humalog (insulin bottle): Discard after 28 days after opening EVEN IF refrigerated. Novolog (insulin bottle): Discard after 28 days after opening EVEN IF refrigerated. Lantus (insulin bottle): Discard after 28 days after opening EVEN IF refrigerated. Humalog KwikPen (insulin pen): Discard after 28 days after opening . Lantus SoloStar (insulin pen): Discard after 28 days after opening . Record review of the facility provided policy titled Storage of Medications revised [DATE], (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revealed the following: Policy Statement:The facility shall store all drugs and biologicals in a safe, secure, and orderly manner.Policy Interpretation and Implementation:2. The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safer, and sanitary manner.4. The facility shall not used discontinued, outdated, or deteriorated drugs or biologicals.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview and record review, the facility failed to employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment requirement for 1 of 1 kitchen staff (Dietary Manager) reviewed for qualifications. The Dietary Manager failed to have the appropriate license, certification, or qualifications to function as the Director of Food and Nutrition Services since her start date in August 2025. This failure could place residents who consume food prepared from the kitchen at increased risk of food borne illness and not receiving adequate nutrition.Findings included: Record review of a current facility employee roster including hire date, indicated the DM's date of hire was 08/01/2025. During an interview on 01/13/26 at 9:05 AM, the ADS stated she had been employed at the facility since August 2025 and was hired as the DM and had been in that role since August. When asked for her certification for DM, she stated she was not certified or enrolled in a class to become certified at this time. During an interview on 01/14/26 at 9:49 AM, the BOM/HR stated that she was responsible for making sure that staff are being trained. She stated the DM was not certified and did not state when her classes will start. The BOM/HR stated that they have a RD who the DM consults with on a regular basis. She stated a negative outcome for not having a trained DM could be malnutrition, choking hazards, and weight loss. In an interview on 01/14/26 at 9:55 AM, the ADM stated the DM was not certified and that BOM/HR was responsible for making sure staff were trained. She stated she thought the DM was supposed to be taking classes and thought she was enrolled but when she asked the BOM/HR person, the ADM stated the DM was not enrolled. She stated a negative outcome for not having a trained DM could be nutritional meals might not be correct. In an interview on 01/15/26 at 10:49 AM, the RD stated that she had been working with the facility since November 2023. She stated that she was not sure if the ADS was certified, but that the ADM would know. The RD stated she consults with the ADS monthly and more if needed. She stated a negative outcome for not having a trained DM could be lack of knowledge on food sanitation and safety. Record review of the facility policy titled Food and Nutrition Services Staff, dated October 2017, included in part: .Policy Statement: The Food Services Department is staffed by food and nutrition services personnel who have demonstrated the skills and competency to carry out the functions of the department.

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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 observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with the professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen sanitation. The facility failed to ensure refrigerated, freezer, and pantry items were properly stored, labeled, and dated.This failure could place residents at risk of food-borne illnesses. Findings included:Observation of the pantry on 01/13/26 at 9:10 AM revealed the following:1. (1) clear container that contained what looked like rice, no label or date.2. (1) clear container that contained what looked like flour, no label.3. (3) cans of vegetable soup - cans were dented.During an interview on 01/13/26 at 9:11 AM, the ADS stated that she puts dented cans in a separate area away from food storage. When shown the 3 cans of dented food on the pantry shelves, she immediately removed them from pantry. Observation of the freezer on 01/13/26 at 9:15 AM revealed the following:1. (1) can of lemonade, no label or date.2. (1) box of what looked to be frozen rolls, open to air, dated, no label.3. (6) individual Italian ices, no label or date.4. (1) box of what looked to be guacamole packs, no label or date. Observation of the refrigerator on 01/13/26 at 9:22 AM revealed the following:1. (1) container of what appeared to be yogurt, no label or date.2. (1) opened container of milk - 1/4 full - no date.3. (1) bag of unidentified meat, dated, unable to read label. 4. (1) box containing 8 wrapped packages of margarine, no label or date. 5. (1) Ziploc bag of meat, no label or date. In an interview on 01/13/26 at 11:28 AM, [NAME] C stated she had worked at the facility for 4 days. She stated it was everyone's responsibility to label and date food and if this did not happen, staff would get in trouble and food could be bad or cause residents to get sick. In an interview on 01/13/26 at 11:37 AM, [NAME] D stated she had worked at the facility for almost a year and everyone who worked in the kitchen was responsible for labeling and dating food. She stated a possible negative outcome was food could mold, and residents could become sick or ill from bad food. In an interview on 01/13/26 at 11:43 AM, [NAME] E stated it was everyone's responsibility to label and date food and if this was not happening, residents could get sick or get food poisoning.In an interview on 01/14/26 at 9:41 AM, the ADS stated she had worked at the facility since August 2025 and that it was everyone's responsibility to label and date food and that not doing it could put residents at risk for not receiving correct food or getting sick. Record review of facility policy, titled Food Receiving and Storage dated October 2017, revealed the following information in part:.Policy Statement: Foods shall be received and stored in a manner that complies with safe food handling practices. 7. Dry foods that are stored in bins will be removed from original packaging, labeled and dated (use by date). 8. All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date). 11. Wrappers of frozen foods must stay intact until thawing.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the assessment accurately reflected the resident's status for 1 (Resident #36) of 15 residents reviewed for accuracy of assessments. The facility failed to ensure Resident #36's MDS was accurately coded to reflect he received insulin. This failure could place residents at risk of not receiving necessary care. Findings Included: Record review of Resident #36's admission record dated 01/14/26 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, unspecified dementia, mild, with other behavioral disturbance (breakdown of thought process causing disruptive behavior), type 2 diabetes mellitus (inability to process sugar), Anxiety disorder (a group of mental illnesses that cause constant fear and worry), major depressive disorder (mental illness causing sadness due to lack of chemicals in the brain that cause happiness) or (Persistent depressed mood), and cognitive communication deficit (impaired thought processes). Record review of Resident #36's annual MDS assessment revealed a completion date of 11/20/25. Section C (Cognitive Patterns) revealed a BIMS score of 00 which indicated the resident's cognition was severely impaired. Section N0300 & N0350 revealed Resident #36 had received insulin in the last 4 days of the 7-day lookback period. Section N0415 J revealed Resident #36 was not taking insulin. Record review of Resident #36's care plan completed on 11/29/25 revealed Resident #36 was taking insulin for his diabetes.Record review of Resident #36's active order summary report dated 01/15/2026 revealed the following orders: .for blood sugar <60, give 8 ounces of juice with 2 tsp sugar po every 30 minutes until blood sugar is greater than 100. <40 give glucogen 1mg IM and notify MD as needed for hypoglycemia. Semglee Subcutaneous solution Pen-Injector 100 Unit/ML. Inject 10 unit subcutaneously at bedtime related to Type 2 Diabetes Mellites without complications .During an interview on 01/15/26 at 9:41 AM, the MDS LVN stated she had worked at the facility for 10 years and was responsible for completing MDS assessments. She stated she used the RAI manual as her policy when completing MDS assessments. When asked if Resident #36's MDS was correct in section N0415 J, the MDS LVN stated she had never seen including insulin after hypoglycemic before now and she would fix the MDS since he takes insulin. The MDS LVN stated a negative outcome of having inaccurate MDS assessments could be that proper care for residents could be affected and it could also affect their funding.During an interview on 01/15/26 at 9:44 AM, the DON stated that the MDS LVN was responsible for MDS assessments. She stated it would be an issue if a resident was taking insulin and not coded for that on their MDS. The DON stated an inaccurate assessment could affect the funding, continuity of care, and could cause their team to not be on the same page regarding medications. She also stated that an inaccurate MDS could impact care for residents because the care plan was based on the MDS.During an interview on 01/15/26 at 9:51 AM, the ADM stated the MDS LVN was responsible for completing MDS assessments. She stated MDS assessments affected facility funding as well as direct care that a resident received.Record review of the Long-Term Care Facility RAI 3.0 User's Manual Version 1.20.1 dated October 2025 revealed the following: . N0415: High-Risk Drug Classes: Use and IndicationN0415J1. Hypoglycemic (including insulin): Check if a hypoglycemic medication was taken by the resident at any time during the 7-day observation period (or since admission/entry or reentry if less than 7 days). N0415J2. Hypoglycemic (including insulin): Check if there is an indication noted for all hypoglycemic medications taken by the resident any time during the observation period (or since admission/entry or reentry if less than 7 days).Include any of these medications given to the resident by any route in any setting (e.g., at the nursing home, in a hospital emergency room) while a resident of the nursing home.Code a medication even if it was given only once during the look-back period.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing in accordance with the comprehensive assessment and plan of care for 1 (Resident #34) of 15 residents reviewed for behavioral health services.The facility failed to ensure Resident #34's comprehensive care plan included goals and interventions addressing his documented diagnosis of post-traumatic stress disorder.This failure could place residents at risk for diminished quality of life due to the lack of treatment and prevention to maintain resident safety.Findings included:Record review of Resident #34's face sheet dated 01/13/2026 revealed he was a [AGE] year-old male resident admitted to the facility on [DATE] with diagnoses to include chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breath),anxiety disorder(feeling panic), bipolar disorder(mood swings), post-traumatic stress disorder, chronic(health condition caused by an extremely stressful event).Record review of Resident #34's last MDS was a quarterly assessment completed 12/18/2025 did not have a BIMS score due to Resident #34 not completing the assessment. In section D0700-Social Isolation- Resident declines to respond. The MDS Assessment further stated his active diagnosis included Post Traumatic Stress Disorder.Record review of Resident #34's care plan latest revision on 01/13/2026 did not mention any goals or interventions related to Resident #34's PTSD. Record review of Resident #34's Trauma Informed assessment dated [DATE] revealed resident had a diagnosis of PTSD. The assessment documented the resident experienced nightmares within the past month of the assessment, frequently on guard and easily startled. The assessment did not include trauma specific guidance or additional information to assist facility staff in providing trauma-informed care.During an interview on 01/13/2026 at 11:20 AM, the MDS LVN stated she and the DON were responsible for updating the care plan with interventions and goals. The MDS LVN stated the absence of trauma informed care measures would be a resident's PTSD may not be addressed. During an interview and observation on 01/13/2026 at 11:25 AM, the DON reviewed Resident #34's care plan and confirmed it did not include goals or care approaches related to the resident's PTSD. The DON stated she and the MDS Coordinator were responsible to ensure care plans were updated and completed with information related to each resident. The DON also stated she was responsible for completing the assessments with residents related to trauma and getting that information in the care plan. The DON stated that a potential negative outcome of not including care approaches and interventions related to resident care would be residents may not get the best care possible.During an observation on 01/14/2026 at 2:00 PM, Resident #34 was in a small group in the activity room, he appeared comfortable in the small group. He did not appear agitated or depressed. He was dressed for the day, sitting in his motorized wheelchair. During an interview on 01/15/2026 at 9:10 AM, LVN B stated she was not aware Resident #34's had PTSD. LVN B stated when time permitted, she reviewed care plans and that it would be beneficial for nursing staff to know what approaches worked best for each resident, including identified triggers. LVN B further stated the DON was responsible for ensuring care plans were updated and completed. During an interview on 01/15/2026 at 9:15 AM, the AD stated documenting care approaches in the care plan assisted her in identifying appropriate activities, resident specific triggers and interventions during activities. She also stated the absence of documented triggers could result in staff inadvertently triggering a resident, which could lead to a negative outcome.On 01/15/2026 at 9:53 AM, a telephone interview with the part time SW was unsuccessful.During an interview and observation on 01/15/2026 at 1:36 PM, Resident #34 reported not feeling well and was observed lying in bed. Resident #34 did not appear depressed or agitated. His room was clean and orderly; his military affiliation flag was hanging near his bed. Resident #34 talked about his time in the (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	military and stated he had PTSD due to events that happened in the military. Because Resident #34 was not feeling well, the interview could not be completed.Record review of Behavioral Assessment, Intervention and Monitoring Policy dated March 2019 reflected the following:.The facility will provide, and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial wellbeing in accordance with the plan of care.