STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675408	A. Building B. Wing	05/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Overton Healthcare Center	1110 Hwy 135 S Overton, TX 75684

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19401 Based on observation, interview, and record review the facility failed implement their written policies and procedures to report an allegation of abuse as required for 1 of 4 residents reviewed for abuse (Resident #1). The facility did not report to HHSC after Resident#1 alleged CNA A and LVN B called him a wet back (a racial slur). This negative finding could cause continued abuse. Findings included: Record review of a face sheet (with no date) indicated Resident#1 was a [AGE] year-old male admitted to the facility on [DATE]. Some of his diagnoses were Parkinson's disease, lack of coordination, reduce mobility, bipolar disorder, and generalized anxiety. Record review of Resident#1 's admission MDS dated [DATE] Indicated a BIMS score of 15 indicating no cognitive impairment. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident#1's baseline care plan dated 5/20/24 indicated a baseline care plan identified resident care needs, reassurance, and goals for the next 48 hours. The short term was the resident's initial goal to have access to services and promote adjustment to a new environment. Some of the approaches were, behavioral needs would be evaluated for impact quality of life, safety, and safety of others. Behavior management plan will be addressed if needed with the physician nurse practitioner and resident representative. Cultural preferences, I will be given a choice to respond with information related to my race and ethnicity and preferred language so that considerations for my cultural needs will be met, including language, barrier culture, religious, food, restrictions, preferences, clothing, medication and healthcare literacy needs . A problem with a start date of 5/20/24 indicated Resident #1 made false accusations cursed belittle and targeted staff members. The resident would be redirected with all negative behaviors to decrease occurrences within the next 90 days of the facility admission. Some of the approaches were all accusations reported by the resident will be addressed by administrator, DON, ADON, and social service. The resident will, be seen by outpatient behavioral program and they will be notified of negative behaviors that may need to be addressed during the resident daily attendance with the program. The resident will be redirected by staff when he begins cursing and being negative toward them or making false allegations. The psychiatric nurse practitioner will be notified of all negative behaviors towards staff. Social services will also be notified of all negative behaviors towards staff. Record review of a grievance form dated 5/20/24 indicated Resident#1 reported that the charge nurse would not give him his medication's last night 5/19/24 initially. Resident#1 then reported the charge nurse approached him around 7:00 p.m. to give him his medications and he refused because it was too early. He said that she came back at 10:00 p.m. and gave him the medications in his hand(he could not take them from his hand due to tremors.) The grievance official follow up was in speaking with the nurse regarding the resident complaints of her, not giving his medications The nurse reported just the opposite of what he said. The nurse (LVN B) said Resident #1 was verbally abuse towards her and other staff. The form was signed by the DON. Record review of Resident#1's grievance form dated 5/20/24 indicated he reported that the charge nurse called him a WB and he reported a CNA A called him a Wet Back also. According to the resident these events occurred 5/18/24 to 5/19/24. The official follow up was the nurse (LVN B) did not know what a Wet Back was. LVN B denied referring Resident #1 as such. The CNA was instructed to limit contact with Resident#1 as he had told several other employees that he did not like her. The form was signed by the DON. Record review of a statement written by CNA A said from 5/18/24 to 5/19/24 CNA A was finishing her assignments for her shift, taking out the trash and taking dirty linen into the laundry room. She said there were coworkers at the nurse's station chatting. She said she was in the lobby, since her relief was already there. Resident #1 was hollering out, she needs to get her A up and help y'all repeatedly. She said Resident #1 also said if you're not going to work, you need to take your B A home go hit the clock. This was signed by CNA A. Record review of another statement written by CNA A dated 5/19/24 and timed at 7:25 p.m. revealed the CNA said she was at the nurse's station charting. Resident #1 came up the hall me a fat A and said that she needed to get up and help the other staff. She said Resident #1 called her a B and and said he will be calling state tomorrow. She said Resident #1 said he was also going to jump on her hollering at the top of his lungs. The nurse was occupied with another resident CNA. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a written statement written by LVN B indicated Resident #1 used abusive language towards staff. On 5/19/24 Resident #1 came to the nurse's station around 8:35 p.m. looking agitated upon asking him what was going on. He went on to curse referring to CNA A as a black fat B. the nurse said she offered Resident #1 his pills at that time, and he refused them and went to his room. Later that night around 11:00 p. m. Resident #1 came down the hallway, screaming at the top of his lungs. Resident #1 said, give me my medicine. The nurse said she received a phone call from the police department saying Resident #1 had called them multiple times. LVN B said she gave him his medication and while she was pulling them up Resident #1 charged towards her trying to hit her. She said Resident #1 later went to his room while still cursing. The statement was signed by LVN B. During an interview on 5/20/24 at 8:30 p.m. LVN B said she had not heard Resident #1 being called any names but had heard him calling other staff names and last night he had called the police four times. She said she had not called him any names, but he had called her plenty of names and none of them were her given name. During an interview on 5/20/24 at 9:03 p.m. CNA A said she had worked on last night 5/19/24 from 6:00 p.m. to 6 a.m. CNA A said she had not called Resident #1 any names. She said Resident #1 was at the nurse's station hollering at the top of his lungs and calling her all kinds of names. She said she did not know why Resident #1 did not like her. She did not provide him any care and did not work on his hall. If he pulled his call light and needed something she would check to see what he needed. She said whenever Resident #1 saw her he would usually begin the name calling. During an interview on 5/20/24 at 9: 15 p.m. the Administrator said Resident #1 told him staff members called him name but they found out Resident #1 called them names. The Administrator said he had written a grievance form. He did not consider the fact that Resident #1 said the staff called him a racial slur verbal abuse. The Administrator said he had 4 staff members that texted in a notice on this morning saying they quit and could not work in a racially discriminatory environment. He said he did not know what they were talking about. He said one of the aides was Hispanic. During an interview on 5/21/24 at 10: 58 a.m. CNA C said she had gotten Resident #1 up and ready for Breakfast this morning. She said Resident #1 told her staff had called him names. He said he was born in this county and was upset that someone would call him a racial slur. He was not an illegal Mexican. During an interview on 5/21/24 12:18 p.m. the ADON said Resident #1 did not like specific staff and CNA A was one of them. He would follow her around and go down the hall or get right in front of her and call her a big black N. The ADON said she had never heard CNA A call him anything. The ADON said she had heard Resident #1 call LVN B names like, little monkey, or black B. The ADON said when they asked LVN B if she had called Resident #1 a WB she said she did not know what that was. The ADON Said LVN B was from [NAME]. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation on 5/21/24 at 3:00 p.m., Resident #1 was sitting in a wheelchair and was being pushed into the dining room by the maintenance man. As he was being pushed into the dining room, Resident #1 was telling the maintenance man how two staff members had called him a WB and no one was doing anything about it. He was saying it was not right and how upset he was to not be treated like everyone else. Resident #1 told the Investigator on the night of 5/19/24 CNA A had called him a Wet Back. He said that was a derogatory name for illegal Mexican's and he was born in this country. He said she had no right to call him that and his rights were violated. He said the LVN B called him a dumb A. He said he heard someone calling out, help, help and he thought someone was in trouble, so he called 911. He told the nurse he had called 911 and the LVN called him a dumb A. He said that facility staff CNA D had heard CNA A call him the WB'. Resident #1 said CNA D and CNA A had words about the incident. He said he had told the Administrator and both staff still worked at the facility, and he did not think that was right. He said it was not right that they could talk to him that way and all they said was he had talked ugly to them instead. Resident #1 said he could not deny that he said a few dirty words that he should not have. Resident #1 said they made him feel dirty like he did not belong. During an interview on 5/21/24 at 3:15 p.m. the Administrator and DON were informed of Resident #1's allegation that CNA A and LVN B had verbally abused him. They said they had spoken with Resident #1 on 5/20/24. They said Resident #1 said LVN B did not give him his medications. He told two different versions of the story. He did say that staff had called him names but interviews with staff had revealed he was the one that called them names. They said they had written statements from the two staff. During a telephone interview on 5/21/24 at 5:04 p.m. CNA D said she heard CNA B call Resident #1 several names including WB. CNA D said CNA A taunted Resident #1 and said thing to him like F you do something about it, she said CNA A told Resident #1 to stand up and do something. She said that was why she left the facility and had not been back. She said the incident happened on a few days ago. CNA D said she was Hispanic and calling someone a Wet Back insinuated that they swam to the US and still had water on their backs, and were not born here, or were illegal. CNA D said she and CNA A had a verbal altercation regarding her calling Resident #1 a WB. CNA D said she told CNA A she heard her and did not appreciate what she said that she was Mexican. CNA D said CNA told her to F you and F your mom. CNA D said she told the ADON, and she promised her she was going to talk to the Administrator and she never did. CNA D said she did not tell the administrator her concerns. However, she quit because they did nothing, and she could not work in that type of environment. During an interview on 5/21/24 at 5:40 p.m. the ADON said no one reported to her there was any name calling regarding Resident #1. She said she heard Resident #1 at the nurse's station where CNA A was charting and told her to get her, fat Black A up and do some work. She said CNA D had texted in with three other CNAs and said she had quit, due to the racially discriminatory environment at the facility. During an interview on 5/21/24 at 5:45 p.m. the Administrator said he had not called in the allegation Resident #1 made about the two staff members calling him names. He said he did not see them calling him a WB as verbal abuse. He said in his professions through the years he had been called all number of names, racial slurs and did not feel it was abuse. He said his investigation into what Resident #1 had told them revealed Resident #1 had called the staff names. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/21/24 at 5:50 p.m. CNA A said she did not call Resident #1 any names. She said he would follow her around and call her all kinds of names and he would do the same to LVN B. The CNA said she had not had any words with CNA D, she said they were at the nurse's station when she was waiting to clock out, but she did not say anything to her or vice versa. Review of the facility Abuse, Neglect and Exploitation policy last revied October 2023 indicated the policy interpretation and implementation was to prohibit and prevent abuse and neglect and exploitation of residents. Identifying, correcting, and intervening in situations in which abuse, neglect, exploitation was more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of residents and assure that staff assigned have the knowledge of the individual residents, care needs and behavioral symptoms. Possible indicators of abuse include but are not limited to resident, staff, or family reports of abuse. Reporting responses. Reporting all alleged violations to the Administrator, state agency, and to all required agencies withing specified time frames. Immediately, but not later than 2 hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury or not later than 24 hours in the events that cause the allegation do not involve abuse and do not result in bodily injury. Promote a culture of safe and open communication in the work environment.