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	01/14/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50818 Based on interviews and record reviews, the facility failed to ensure the residents had the right to be free from abuse for 3 of 11 residents (Residents #1, #2 and #3) reviewed for abuse. The facility failed to protect Resident #2 from Physical Abuse when Resident #1 slapped her in the face on 10/27/2024. The facility failed to protect Resident #1 from Physical Abuse when Resident #3 pulled Resident #1 by her shirt collar on 12/11/2024. This failure could place residents at risk for abuse, physical or psychological harm or injury. Findings included: Record review of an Admission Record for Resident # 1 indicated she was admitted to the facility on [DATE] and was [AGE] years old. Her diagnoses included dementia (affect thinking and activities of daily life), Alzheimer's disease (progressive disease that affects thinking), and vascular dementia with mood disturbance. (a form of dementia caused by reduced or blocked blood flow to the brain). Record review of an Annual MDS assessment dated [DATE] for Resident #1 indicated she had a BIMS score of 0 indicating severe impairment in cognition. Physical symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) and other behavioral symptoms not directed towards others (e.g., hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) occurred 1-3 days. Her functional status with most activities of daily living indicated she required extensive assistance. She was ambulatory and did not require any assistance with mobility. (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

Printed: 03/27/2025
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a Care Plan last revised on 1/13/2025 for Resident #1 indicated she had episodes of inappropriate behaviors with a tendency to invade other residents' space, getting in other resident's beds, and taking other resident's food at mealtimes. Interventions were in place including diversional activities, redirection, keeping environment calm and relaxed, and serving resident first at mealtime. She resides on the secured unit due to an elopement risk related to diagnosis of Dementia, anxiety, and psychosis with wandering and poor safety awareness. Interventions for resident safety in place prior to 10/27/24 included secure unit placement, elopement assessments, staff to monitor and report exit seeking behavior, and keeping resident an an area of maximum supervision. Resident #1's care plan indicated new interventions were added on 10/28/24 to ensure resident safety including Psychiatric Nurse Practitioner consult and medication changes with interventions to monitor for side effects. Resident #1's care plan indicated new interventions were added on 12/12/24 to ensure resident safety including Psychiatric Telehealth visit, encouraging diversional activities, keeping environment calm and relaxed, redirecting resident, and serving resident first at meal time. Resident #1's care plan was revised on 1/03/25 and included interventions serve her food first at mealtimes to prevent her attempting to take food from another resident. Record review of an Admission Record for Resident # 2 indicated she was admitted to the facility on [DATE] and was [AGE] years old. Her diagnoses included Alzheimer's disease (progressive disease that affects thinking), and unspecified dementia (affects thinking and activities of daily life). She was discharged home on 12/31/2024 due to family preference. Record review of an Annual MDS assessment dated [DATE] for Resident #2 indicated she had a BIMS score of 3 indicating severe impairment in cognition. Her functional status with most activities of daily living indicated she required maximal assistance or was dependent. Record review of the Care Plan dated 12/30/2024 for Resident #2 indicated she had impulsive behaviors and poor insight into own abilities. Interventions were in place including encouraging her to allow staff assistance. Record review of an Admission Record for Resident # 3 indicated she was admitted to the facility on [DATE] and was [AGE] years old. Her diagnoses included Cerebral infarction (occurs when the blood supply to part of the brain is blocked or reduced), and unspecified dementia (affects thinking and activities of daily life). Record review of an Annual MDS assessment dated [DATE] for Resident #3 indicated she had a BIMS score of 0 indicating severe impairment in cognition. Her functional status with most activities of daily living indicated she required substantial assistance or was dependent. Record review of the Care Plan dated 12/13/2024 for Resident #3 indicated she had behavioral problems related to diagnoses of schizophrenia and dementia which lead to wandering and poor safety awareness. Interventions in place included placement in secured unit, and quarterly and significant elopement assessments. Record review of a Nursing Progress Note dated 10/27/2024 at 5:57 PM by LVN C indicated Resident #1 . walked up and slapped another resident (Resident #2) in the face; leaving a red handprint on the other residents Left cheek . Resident #2 was noted to have no additional injuries. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a Nursing Progress note dated 10/27/2024 by LVN C (entered as a late entry on 10/29/2024) indicated LVN C was alerted by CNA B of a resident-to-resident altercation on a women's memory care unit. In the same progress note LVN C noted Resident #1 pacing the area, agitated and mumbling incoherently to herself. Resident #2 was sitting in her wheelchair in the dining area holding her left cheek and crying. Record review of a Nursing Progress note dated 10/28/2024 at 10:17 PM by LVN H indicated Resident #2 had no delayed injuries and no complaints of pain or discomfort. Record review of an Event Report dated 10/27/2024 indicated Resident #1 slapped Resident #2 in the face, the event was unwitnessed. Resident #1 had no noted injuries, Resident #2 had faint redness to her left cheek. Both residents were observed for 24 hours without further incident. Both residents were separated and monitored for 24 hours. Mental health NP and Abuse Coordinator, which is the Administrator, were immediately notified. Record review of inservice dated 10/29/2024 titled, Abuse, Neglect, and Incidents Reportable to HHSC/DADS, completed after incident included instruction on HHSC Provider Letter. Record review of a LMSW Progress Note dated 11/11/2024 by Social Worker indicated Resident #1 had experienced physical and cognitive decline since admission, she was often resistant to care and combative with staff and had episodes of threating to hit other residents. Record review of a Nursing Progress Note dated 12/11/2024 by LVN D indicated she heard noises coming from a women's secured unit and upon entering saw staff separating Resident #1 and Resident #3. CNA E said Resident #1 was standing over Resident #3 when Resident #3 grabbed Resident #1's shirt collar and pulled her down then let her go. Resident #1 had scratches on her face. Resident #3 was assessed by the nurse and no injuries were noted. Record Review of Event Report dated 12/11/2024 indicated Resident #1 and Resident #3 were immediately separated and monitored for 24 hours including neurological checks. Mental health NP and Abuse Coordinator, which is the Administrator, were immediately notified. Record review of Inservice dated 12/12/2024 titled Abuse, Neglect and Exploitation And Resident to Resident Altercations; Reporting Allegations of abuse, including Long-Term Care Regulation Provider Letter. During an interview on 1/13/2025 at 12:45 PM CNA F said Resident #1 tried to take food off Resident #3's tray and Resident #3 grabbed her by the shirt collar and pulled her down. She said there were scratches on Resident #1's face after the altercation. She said neither resident altered their activities following the incident. She said she heard resident #2 yell from the dining room and when she entered Resident #1 was pacing in the dining room while Resident #2 was holding her left cheek. She said Resident #2 said she hit me referring to Resident #1. She said she has been inserviced on abuse and neglect and resident to resident altercations. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/13/2025 at 1:00 PM CNA E said she was passing out trays when she heard residents yelling in the dining room. She said when she entered the dining room Resident #3 was holding on to Resident #1's shirt and pulling her down. She said she saw scratches on Resident #1's face after the residents were separated. She said she has been inserviced on abuse and neglect and resident to resident altercations. During an interview on 1/13/2025 at 1:34 PM ADON said Resident #1 tries to take food off other resident trays. She said interventions had been added to serve her first at meals. She said 1 CNA is assigned to a secured hall and they are expected to round at least every 2 hours. She said supervisors walk the halls too and relieve CNAS if they are off the floor for breaks or assisting residents. She said all staff had been inserviced on abuse and neglect and resident to resident altercations. During an interview on 1/14/25 at 5:00 PM DON said she was ultimately responsible for supervision of nursing and CNA staff. She said 1 CNA was assigned to each memory care hallway and nurses and managers supervise the units when a CNA is on break or busy with patient care. She said it was the expectation CNAs are to call or text supervisors whenever they need assistance with supervision on secured units. She said all staff had been inserviced on abuse and neglect and resident to resident altercations. She said the risks to residents who are not supervised include physical injury and disrupting the unit. She said going forward she will emphasize supervision. During an interview on 1/14/25 at 5:10 PM the Administrator said all staff has been inserviced on abuse and neglect and resident to resident altercations. He said going forward he plans to provide more training to staff and encourage them to utilize available resources and ask for help when necessary. Record review of policy titled Abuse Prevention Program last revised 1/9/23 indicated .Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation .