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	08/13/2025

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents remained free from physical abuse for 1 of 8 residents (Resident #1) reviewed for physical abuse.The facility failed to protect Resident #1 from resident-to-resident physical abuse on 7/16/25 when Resident #2 hit Resident #1 with a television cord, a nightstand drawer, and a wheelchair footrest causing injuries including facial and scalp lacerations, a fractured globe of the left eye, and a nasal fracture.An Immediate Jeopardy (IJ) situation was determined to have begun on 7/16/2025 and ended on 7/18/25. It was determined to be past non-compliance due to the facility having implemented actions that corrected the non-compliance prior to the beginning of the survey. This failure could place all residents at risk for serious injury and hospitalization.Findings included: Record review of Resident #1's admission record, dated 8/12/25, indicated he was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included vascular dementia (decline in cognitive function), muscle wasting (atrophy), muscle weakness, and unspecified lack of coordination. Record review of Resident #1's significant change MDS, dated [DATE], indicated he had severely impaired thinking with a BIMS of 7. He required moderate assistance with personal hygiene, putting on/taking off footwear, lower body dressing, and showering/bathing; he required supervision assistance with toileting hygiene and upper body dressing; he required setup or cleanup assistance with oral hygiene and eating. He was frequently incontinent of bowel and bladder.Record review of Resident #1's comprehensive care plan, revised 7/15/25, indicated he had limited ability to walk related to impaired gait. Appropriate interventions were in place including providing dependent assistance for walking, instruct in use of a rolling walker, and remind resident not to walk without assistance. Record review of Resident #2's admission record, dated 8/12/25, indicated he was a [AGE] year-old male readmitted to the facility on [DATE] with diagnoses of vascular dementia, mood disorder, unspecified symptoms involving cognitive functions and awareness. Record review of Resident #2's optional state assessment MDS dated [DATE] indicated he had severely impaired cognition with a BIMS of 5. He required supervision for most ADLs. Record review of Resident #2's comprehensive care plan dated 9/04/24 indicated he had exhibited socially inappropriate and disruptive behaviors including aggression and verbal aggression towards others. Appropriate interventions were in place including avoid over-stimulating environments, intervene early if resident behavior endangers the resident or others, and maintain a calm, slow, understandable approach with resident. During an interview on 8/12/25 at 9:10 a.m., the ADM said Resident #2 was admitted to the facility from a state facility and was required to be housed in a nursing facility as a condition of his release. The ADM said Resident #2 had no history of physical aggression towards other residents but had been verbally aggressive at times. The ADM said the facility acted immediately upon learning of the resident-to-resident altercation. The ADM said the facility performed all appropriate notifications and Resident #2 was placed under arrest by city police department. The ADM said Resident #1 was transported to the ER for evaluation and treatment and later returned to the facility. During an interview and observation on 8/12/25 at 3:30 p.m., Resident #1 was observed in his room, lying in bed. He appeared clean and well-groomed with no offensive odors detected. His left eye was closed, and he showed no fear interacting with staff or other residents. Resident #1 said on the night of the resident-to-resident altercation he woke up to use the bathroom. Resident #1 said he was sitting on the side of his bed using a hand-held urinal when Resident #2 told him to quit shaking my dick at him. Resident #1 said he told Resident #2 to stop staring at him, finished using the urinal, and laid back down in bed. Resident #1 said Resident #2 came over to his bed and started hitting him in the face and head with an electrical cord, which he believed was from the television in the room. Resident #1 said he tried to get up from bed but fell onto the floor. Resident #1 said Resident #2 picked up the television and threw it on top of him. Resident #1 said Resident #2 removed the metal footrest from Resident #1's wheelchair and began hitting him in the legs with it. Resident #1 said Resident #2 then pulled a drawer out of the bedside table and hit him in the left side of his face/head with it. Resident #1 said he was unable to get up or defend himself and yelled for help. Resident #1 said he still has pain in his left eye and can not see out of it well. Resident #1 said he had to have surgery, and it would be a few weeks before he could see well.Record review of a witness statement dated 7/17/25 by CNA Q indicated .On July 16, 2025, around midnight I just finished rounds.I heard the ice machine drop ice then another boom then 3 more [NAME].When I got about halfway down c hall, about where the wooden phone booth is, [Resident #2] met me in the hall coming out of

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received adequate supervision to prevent accidents for 1 of 8 residents (Resident #3) reviewed for accidents.The facility failed to keep Resident #3 in a safe environment to prevent an elopement on 7/27/2025 when he followed visitors out of the facility.An Immediate Jeopardy (IJ) situation was determined to have begun on 07/27/2025 and ended on 08/01/2025. It was determined to be past non-compliance due to the facility had corrected the noncompliance before the survey began. This failure could place residents at risk for serious injury and accidentsFindings included: Review of an undated admission record for Resident #3 indicated he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of Alzheimer's disease (progressive cognitive decline) and schizoaffective disorder, bipolar type (combines schizophrenia and bipolar features). Review of a quarterly MDS dated [DATE] indicated he had a BIMS of 0 which indicated severe cognitive impairment. He required total assistance with toileting and personal hygiene; he required substantial assistance with showering/bathing; he required moderate assist putting on/taking off footwear, and with upper and lower body dressing; he required setup or cleanup assistance eating and with oral hygiene. Review of the comprehensive care plan dated 9/4/25 indicated Resident #3 was at risk for elopement related to diagnoses of Alzheimer's disease, dementia (cognitive decline), and schizoaffective disorder. Appropriate interventions were in place including wearing a Wander Guard bracelet (device that alarms if wearer was close to the facility exit doors), checking placement and function every shift, and quarterly or as needed elopement assessments to be completed.During an interview on 8/12/25 at 9:05 a.m., the DON said Resident #3 followed visitors out of the facility on 7/27/25. The DON said Resident #3 had a wander guard bracelet in place at the time of the elopement, but the alarm did not activate. The DON said when a resident had interventions to wear a wander guard the nursing staff checked the device every shift for placement and functionality and signed the wander guard logbook to indicate the checks were completed. The DON said she was not sure why the wander guard alarm system did not activate, but repairs were made to the system. The DON said the maintenance man had begun checking all alarms and door locks daily in addition to continuing the scheduled weekly maintenance checks. During an interview on 8/12/25 at 9:10 a.m., the ADM said at the time of the elopement on 7/27/25, Resident #3 was being housed on Hall A and was wearing a wander guard bracelet. The ADM said the wander guard alarm system was tested daily by the nursing staff when a resident was wearing one in the facility, and the door locks and alarms were checked weekly by the maintenance man. The ADM said he was unsure why the wander guard alarm did not activate. The ADM said he had service technicians come to the facility on 7/31/25 and make repairs to the alarm system. The ADM said Resident #3 was moved onto the secure men's unit following the elopement.Review of a witness statement dated 7/28/25 at 1:21 p.m., indicated at approximately 6:20 p.m. a woman visiting the facility rang the doorbell and asked LVN A if the man in the parking lot was a resident. LVN A said she immediately went outside and located Resident #3 walking by the dumpsters. LVN A said she led Resident #3 back inside the building. Review of a witness statement dated 7/30/25 by a visitor indicated on 7/27/25 she and several other visitors exited the facility through the front door. She said Resident #3 was near the nurse's station when they were walking up the hall to the lobby. She said after they exited the facility another visitor noted Resident #3 in the parking lot and went back inside the facility to alert facility staff. Review of an Elopement Event Report dated 7/31/25 at 2:16 p.m., completed by the DON indicated Resident #3 eloped from the facility on 7/27/25 at approximately 6:31 p.m. and was located in the front parking area. The report indicated there had been no recent changes in mental status, no recent traumatic events, new diagnosis, new stressors, or medication changes prior to the elopement. The report indicated Resident #3 was assessed for secure unit placement and moved to the men's secure unit.During an observation and interview on 8/12/25 at 10:52 a.m., Resident #3 was in sitting in the dining room of the men's secured unit. He appeared clean and well-groomed with no offensive odors; he had no visible skin tears, marks, or bruising. Resident #3 said he went outside the facility but could not provide any detail as to when, why or how. During an interview on 8/12/25 at 10:30 a.m., LVN B said Resident #3 was the only resident in the facility care planned for a wander guard. LVN B said nurses were responsible for checking the placement and function of wander guards every shift and signing the wander guard book to indicate checks were completed. LVN B said she was not aware of any problems with the wander guard alarm system prior to the elopement on 7/27/25. During an interview