STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675408	A. BUILDING _____ B. WING _____	05/23/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0224 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Write and use policies that forbid mistreatment, neglect and abuse of residents and theft of residents' property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement their policies and procedures to prohibit neglect for 4 of 5 residents reviewed for neglect. (Resident #s 1, 2, 6 and 5) Resident #1 was placed on the secure unit due to a history of aggressive behaviors and need for supervision at all times. Resident #1 was aggressive toward Resident #2. The facility did not put measures into place to protect Resident #2. Resident #1 threw hot coffee on Resident #2's face causing redness to the resident's neck. Two days later, Resident #2 wandered into Resident #1's room, Resident #1 grabbed Resident #2 and hit him in the face repeatedly. Resident #6 had a history of [REDACTED]. She was admitted to the secure unit on 5/14/14 in handcuffs. She had to be separated from other residents and threatened to stab the DON with a fork. Resident #5 had a history of [REDACTED]. Resident #5 was assigned to the locked unit due to putting his hands in other resident ' s food. Resident #5 repeatedly grabbed food from another resident's plate without staff intervention. The staff did not intervene to prevent Resident #5 from grabbing food off other residents' plates. This failure could place the census of 57 residents at risk for abuse and injury. Findings included: 1. Physician orders [REDACTED].#1 was [AGE] years old, admitted on [DATE] with [DIAGNOSES REDACTED]. Resident #1's most recent MDS dated [DATE] indicated he was independent in all ADLs. A care plan, dated 04/10/14, indicated Resident #1 was assigned to the secure unit as a requirement of the parole board due to potential for harm to others. Approaches included staff monitoring his whereabouts and safety at all times . Physician orders [REDACTED].#2 was [AGE] years old, admitted on [DATE] with [DIAGNOSES REDACTED]. The most recent MDS dated [DATE] indicated Resident #2 exhibited wandering behaviors. A care plan, dated 03/19/14, indicated Resident #2 was assigned to the secure unit due to risk of injury from wandering in an unsafe environment . Approaches included staff monitoring every hour for safety. Incident Report dated 04/29/14 indicated Resident #1 threw coffee in Resident #2's face. The report noted slight redness to the right side of Resident #2's neck. A nursing note, dated 05/01/14 indicated Resident #1 had another resident (Resident #2) against the wall while punching the resident in the face. During an interview on 05/14/14 at 8:30 a.m. CNA A, CNA B, and LVN C said they worked the secured unit where Resident #2 resided. They said the unit had 12 residents that all exhibit behaviors and require assistance with ADLs. They said the unit was staffed with one CNA. They said one CNA could not provide the required care, supervision, and monitor residents for behaviors. They said the LVN was not stationed on the unit and was assigned to two other hallways. They said Resident #1 and #2 had previous incidents; Resident #1 was aggressive and seemed to get into it with Resident #2 more over the past few weeks. During an interview on 05/14/14 at 9:00 a.m., the DON said Resident #1 was admitted from a halfway house to the secured unit. She said Resident #1 and # 2 were roommates until Resident #1 started picking on Resident #2. She said Resident #1 started picking on the resident immediately. She said after the residents were separated, Resident #2 still went into his previous room thinking it was his which upset Resident #1. She said most residents on the secure unit had dementia with behaviors and required assistance with ADLs. The DON said on 04/29/14 Resident #1 threw hot coffee on Resident #2. She said on 05/01/14 Resident #1 repeatedly hit Resident #2. She said Resident #2 did not suffer any injuries and the residents were separated immediately and the police removed Resident #1 from the facility after the responsible party filed charges against Resident #1. The DON said the facility attempted to keep the residents separated, but neither could be removed from the secure unit. She said the secure unit was staffed with one CNA. The DON said the facility identified a need for increased staff on the men ' s secured unit, but had not implemented additional staff on the unit. She said Resident #2's family removed him from the facility after the incident. A Provider Investigation Report dated 4/29/14 indicated Resident #2 was discharged on [DATE]. During an interview on 5/22/14 at 7:25 p.m., CNA F and CNA G said Resident #1 and Resident #2 had two altercations in the middle of April 2014. They described one altercation as Residents # 1 and 2 tousling over a walker. CNA F and CNA G said Resident #1 was protective of his things and Resident #2 was trying to take the walker. They said the residents were separated and the nurse was informed. They said a few days later Resident #1 had Resident #2 pinned against the wall attempting to hit him. They said the residents were separated and the nurse was informed. 2. A Special Unit Evaluation and Review Form, dated 11/25/13, indicated Resident #5 was assigned to the locked unit due to putting his hands in other resident ' s food. The form indicated there was no documentation to support. During an observation on 05/14/14 at 8:15 a.m., Resident #5 put his hand into a another resident's food tray twice, each time the resident tapped Resident #5's hand and shook his finger in Resident #5's face. CNA A, the only staff on the men ' s secured unit, was feeding another resident. CNA A turned and looked at Resident #5 but continued feeding the resident. Resident #5 continued to put his hand in the other resident's food tray, each time the resident tapped Resident #5's hand and shook his finger in Resident #5's face. He attempted to assist Resident #5 with eating his meal and after the third time firmly said no to Resident #5. CNA A stopped feeding the other resident and approached Resident #5, redirected him, and returned to feeding the other resident. Resident #5 again attempted to grab food off the other resident's food tray and the other resident grabbed Resident #5's hand. 3. The undated Resident Admission Record indicated Resident#6 was a [AGE] year old female admitted [DATE] with a [DIAGNOSES REDACTED]. A telephone physician order [REDACTED].# 6 was to be admitted to the female unit for behavior issues. A crisis assessment dated [DATE] indicated Resident #6 believes she has to kill people for the government. Treatment recommendations were that Resident #6 was very delusional at this time- to the point where she is a danger to herself/others and hospitalization is recommended. A physician note dated 5/4/14 indicated Resident #6 was evaluated after reports of being aggressive toward staff at a local nursing home. A crisis reassessment dated [DATE] indicated Resident #6 was on a waiting list for the local state hospital. Nursing notes for Resident # 6 indicated the following: *5/14/14 at 6:45 pm. the resident was brought to the facility in hand cuffs by the sheriff ' s office. The police said she had hit two staff members. The resident had bruising on her arm. *5/15/14 at 2:00 a.m., Resident #6 was asleep. She can be combative at times. * 5/15/14, no time, resident refused to take medications and threatened to stab the DON with a fork. She was sent to the hospital for an evaluation. A Resident Monitoring Checks sheet indicated Resident #6 was placed on 15 minute checks on 5/15/14 at 12:00 p.m., with the last one documented at 9:00 p.m. The sheet indicated she was placed on 15 minute checks due to refusal to be checked, screaming, refusing to get out of bed and very violent. At 2:00 (no indication of am or pm) noted Resident #6 did not want the door closed. Resident # 6 was holding a conversation with herself. She exhibit verbal abuse by yelling and cursing. During an interview on 5/22/14 at 11:37 a.m., CNA E said Resident #6 was non-compliant with care. She said Resident #6 cursed, screamed and would not change her clothes or get out of bed. CNA E said on the second shift she was really combative and she had to keep the other residents away from her. CNA E said Resident #6 ' s roommate was asked to stay in the day room when she became aggressive towards her. CNA E said she reported Resident #6 ' s behaviors to the DON. During an interview on 5/22/14 at 1:09 p.m., the DON said Resident #6 was accepted to the facility from the hospital. She said they were not aware of her aggressive behaviors or history. She said

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

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.

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F 0224 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 1) Resident #6 was assessed for admission based on paperwork sent from the hospital. The DON said Resident #6 was admitted after business hours. She said Resident #6 was conked out on medications. The DON said apparently Resident #6 woke up the next morning and would not do anything but curse and be combative to staff. The DON said she attempted to reason with Resident #6, but she would not take medications or sign admission paperwork. She said at dinner time Resident #6 threatened to stab her with a fork. The DON said Resident #6 was sent to the hospital for a psychiatric evaluation. She said they were informed by cooperate office not to take her back because technically she was not their resident because Resident #6 was in the facility less than 24 hours. During an interview on 5/22/14 at 1:51 p.m., a staff from the admitting hospital said Resident #6 was totally delusional and hallucinating. She said there was no way Resident #6 should have been admitted to the nursing home. She said Resident #6 was now at the local state hospital due to her mental state. Daily staffing sheets and time sheets from 04/01/14 to 05/14/14 indicated one CNA was assigned to and worked the secure unit on each shift. The facility's revised Abuse and Neglect Policy and Procedure dated 11/11/11 indicated, .allegations are immediately reported to the appropriate Agencies and then a thorough investigation is initiated .when an alleged or suspected care of mistreatment, neglect and injuries of an unknown source or abuse is reported, the facility administrator or his/her designee will notify the Department of Aging and Disability Services .Neglect is failure to provide goods and service necessary to avoid physical harm, mental anguish or mental illness. An information for onsite form dated 5/14/14 indicated a census of 57 residents.
F 0226 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement their written policies and procedures to prohibit neglect for 4 of 5 residents reviewed for neglect. (Resident #s 1, 2, 6 and 5) Resident #1 was placed on the secure unit due to a history of aggressive behaviors and need for supervision at all times. Resident #1 was aggressive toward Resident #2. The facility did not put measures into place to protect Resident #2. Resident #1 threw hot coffee on Resident #2's face causing redness to the resident's neck. Two days later, Resident #2 wandered into Resident #1's room, Resident #1 grabbed Resident #2 and hit him in the face repeatedly. Resident #6 had a history of [REDACTED]. She was admitted to the secure unit on 5/14/14 in handcuffs. She had to be separated from other residents and threatened to stab the DON with a fork. Resident #5 had a history of [REDACTED]. Resident #5 was assigned to the locked unit due to putting his hands in other resident ' s food. Resident #5 repeatedly grabbed food from another resident's plate without staff intervention. The staff did not intervene to prevent Resident #5 from grabbing food off other residents' plates. This failure could place the census of 57 residents at risk for abuse and injury. Findings included: The facility's revised Abuse and Neglect Policy and Procedure dated 11/11/11 indicated, .allegations are immediately reported to the appropriate Agencies and then a thorough investigation is initiated .when an alleged or suspected care of mistreatment, neglect and injuries of an unknown source or abuse is reported, the facility administrator or his/her designee will notify the Department of Aging and Disability Services .Neglect is failure to provide goods and service necessary to avoid physical harm, mental anguish or mental illness. 1. Physician orders [REDACTED].#1 was [AGE] years old, admitted on [DATE] with [DIAGNOSES REDACTED]. Resident #1's most recent MDS dated [DATE] indicated he was independent in all ADLs. A care plan, dated 04/10/14, indicated Resident #1 was assigned to the secure unit as a requirement of the parole board due to potential for harm to others. Approaches included staff monitoring his whereabouts and safety at all times . Physician orders [REDACTED].#2 was [AGE] years old, admitted on [DATE] with [DIAGNOSES REDACTED]. The most recent MDS dated [DATE] indicated Resident #2 exhibited wandering behaviors. A care plan, dated 03/19/14, indicated Resident #2 was assigned to the secure unit due to risk of injury from wandering in an unsafe environment . Approaches included staff monitoring every hour for safety. Incident Report dated 04/29/14 indicated Resident #1 threw coffee in Resident #2's face. The report noted slight redness to the right side of Resident #2's neck. A nursing note, dated 05/01/14 indicated Resident #1 had another resident (Resident #2) against the wall while punching the resident in the face. During an interview on 05/14/14 at 8:30 a.m. CNA A, CNA B, and LVN C said they worked the secured unit where Resident #2 resided. They said the unit had 12 residents that all exhibit behaviors and require assistance with ADLs. They said the unit was staffed with one CNA. They said one CNA could not provide the required care, supervision, and monitor residents for behaviors. They said the LVN was not stationed on the unit and was assigned to two other hallways. They said Resident #1 and #2 had previous incidents; Resident #1 was aggressive and seemed to get into it with Resident #2 more over the past few weeks. During an interview on 05/14/14 at 9:00 a.m., the DON said Resident #1 was admitted from a halfway house to the secured unit. She said Resident #1 and # 2 were roommates until Resident #1 started picking on Resident #2. She said Resident #1 started picking on the resident immediately. She said after the residents were separated, Resident #2 still went into his previous room thinking it was his which upset Resident #1. She said most residents on the secure unit had dementia with behaviors and required assistance with ADLs. The DON said on 04/29/14 Resident #1 threw hot coffee on Resident #2. She said on 05/01/14 Resident #1 repeatedly hit Resident #2. She said Resident #2 did not suffer any injuries and the residents were separated immediately and the police removed Resident #1 from the facility after the responsible party filed charges against Resident #1. The DON said the facility attempted to keep the residents separated, but neither could be removed from the secure unit. She said the secure unit was staffed with one CNA. The DON said the facility identified a need for increased staff on the men ' s secured unit, but had not implemented additional staff on the unit. She said Resident #2's family removed him from the facility after the incident. A Provider Investigation Report dated 4/29/14 indicated Resident #2 was discharged on [DATE]. During an interview on 5/22/14 at 7:25 p.m., CNA F and CNA G said Resident #1 and Resident #2 had two altercations in the middle of April 2014. They described one altercation as Residents # 1 and 2 tousling over a walker. CNA F and CNA G said Resident #1 was protective of his things and Resident #2 was trying to take the walker. They said the residents were separated and the nurse was informed. They said a few days later Resident #1 had Resident #2 pinned against the wall attempting to hit him. They said the residents were separated and the nurse was informed. 2. A Special Unit Evaluation and Review Form, dated 11/25/13, indicated Resident #5 was assigned to the locked unit due to putting his hands in other resident ' s food. The form indicated there was no documentation to support. During an observation on 05/14/14 at 8:15 a.m., Resident #5 put his hand into a another resident's food tray twice, each time the resident tapped Resident #5's hand and shook his finger in Resident #5's face. CNA A, the only staff on the men ' s secured unit, was feeding another resident. CNA A turned and looked at Resident #5 but continued feeding the resident. Resident #5 continued to put his hand in the other resident's food tray, each time the resident tapped Resident #5's hand and shook his finger in Resident #5's face. He attempted to assist Resident #5 with eating his meal and after the third time firmly said no to Resident #5. CNA A stopped feeding the other resident and approached Resident #5, redirected him, and returned to feeding the other resident. Resident #5 again attempted to grab food off the other resident's food tray and the other resident grabbed Resident #5's hand. 3. The undated Resident Admission Record indicated Resident#6 was a [AGE] year old female admitted [DATE] with a [DIAGNOSES REDACTED]. A telephone physician order [REDACTED].# 6 was to be admitted to the female unit for behavior issues. A crisis assessment dated [DATE] indicated Resident #6 believes she has to kill people for the government. Treatment recommendations were that Resident #6 was very delusional at this time- to the point where she is a danger to herself/others and hospitalization is recommended. A physician note dated 5/4/14 indicated Resident #6 was evaluated after reports of being aggressive toward staff at a local nursing home. A crisis reassessment dated [DATE] indicated Resident #6 was on a waiting list for the local state hospital. Nursing notes for Resident # 6 indicated the following: *5/14/14 at 6:45 pm. the resident was brought to the facility in hand cuffs by the sheriff ' s office. The police said she had hit two staff members. The resident had bruising on her arm. *5/15/14 at 2:00 a.m., Resident #6 was asleep. She can be combative at times. * 5/15/14, no time, resident refused to take medications and threatened to stab the DON with a fork. She was sent to the hospital for an evaluation. A Resident Monitoring Checks sheet indicated Resident #6 was placed on 15 minute checks on 5/15/14 at 12:00 p.m., with the last one documented at 9:00 p.m. The sheet indicated she was placed on 15 minute checks due to refusal to be checked, screaming, refusing to get out of bed and very violent. At 2:00 (no indication of am or pm) noted Resident #6 did not want the door closed. Resident # 6 was holding a conversation with herself. She exhibit verbal abuse by yelling and cursing. During an interview on 5/22/14 at 11:37 a.m., CNA E said Resident #6 was non-compliant with care. She said Resident #6 cursed, screamed and would not change her clothes or get out of bed. CNA E said on the second shift she was really combative and she had to keep the other residents away from her. CNA E said Resident #6 ' s roommate was asked

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F 0226 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 2) to stay in the day room when she became aggressive towards her. CNA E said she reported Resident #6 ' s behaviors to the DON. During an interview on 5/22/14 at 1:09 p.m., the DON said Resident #6 was accepted to the facility from the hospital. She said they were not aware of her aggressive behaviors or history. She said Resident #6 was assessed for admission based on paperwork sent from the hospital. The DON said Resident #6 was admitted after business hours. She said Resident #6 was conked out on medications. The DON said apparently Resident #6 woke up the next morning and would not do anything but curse and be combative to staff. The DON said she attempted to reason with Resident #6, but she would not take medications or sign admission paperwork. She said at dinner time Resident #6 threatened to stab her with a fork. The DON said Resident #6 was sent to the hospital for a psychiatric evaluation. She said they were informed by cooperate office not to take her back because technically she was not their resident because Resident #6 was in the facility less than 24 hours. During an interview on 5/22/14 at 1:51 p.m., a staff from the admitting hospital said Resident #6 was totally delusional and hallucinating. She said there was no way Resident #6 should have been admitted to the nursing home. She said Resident #6 was now at the local state hospital due to her mental state. Daily staffing sheets and time sheets from 04/01/14 to 05/14/14 indicated one CNA was assigned to and worked the secure unit on each shift. The facility's revised Abuse and Neglect Policy and Procedure dated 11/11/11 indicated, .allegations are immediately reported to the appropriate Agencies and then a thorough investigation is initiated .when an alleged or suspected care of mistreatment, neglect and injuries of an unknown source or abuse is reported, the facility administrator or his/her designee will notify the Department of Aging and Disability Services .Neglect is failure to provide goods and service necessary to avoid physical harm, mental anguish or mental illness. An information for onsite form dated 5/14/14 indicated a census of 57 residents.
F 0323 **Level of harm** - Actual harm **Residents Affected** - Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide supervision to prevent hot beverage burns for 1 of 5 residents reviewed for accidents. (Resident #2) Resident #2 was not assessed for his ability to manage hot beverages. Resident #2 sustained blisters to his legs while serving himself coffee. This failure could place 12 residents on the men ' s secure unit at risk for injury. Findings included: Physician orders [REDACTED].#2, admitted [DATE], was [AGE] years old with [DIAGNOSES REDACTED]. The most recent MDS dated [DATE] indicated Resident #2 had severely impaired cognitive skills for daily decision making, was unsteady, used a wheelchair and walker for mobility, and required supervision with setup help with eating. A comprehensive care plan revised 03/19/14 indicated Resident #2 was at risk for injury from wandering in an unsafe environment. Approaches included monitoring every hour and as needed to keep the resident ' s environment safe from possible hazards. The care plan indicated the resident required assistance with ADLs. The clinical record for Resident #2 did not have an evaluation to determine his ability to manage hot beverages. An Incident Report dated 04/25/14 indicated Resident #2 was assessed in his room with five blisters on his legs, three to both of his lower legs and one on each thigh. Resident #2 stated coffee when asked what happened. A Provider Investigation Report dated 4/29/14 indicated Resident #2 was discharged on [DATE]. A Provider Investigation Report dated 5/6/14 indicated Resident #2 received blisters to the right and left lower leg. The investigation summary indicated dietary staff saw Resident #2 getting coffee all day in a large plastic cup. During an interview on 05/14/14 at 2:00 p.m., LVN C said she assessed Resident #2 on 4/25/14 and discovered blisters on his legs. She said she was unsure of what occurred, but Resident #2 said coffee when she asked him how the blisters occurred. During an interview on 05/14/14 at 8:30 a.m., CNA A, said she worked the men ' s secure unit where Resident #2 resided. She said she was not aware Resident #2 spilled coffee on himself. She said residents continued to freely serve themselves coffee. She said 12 residents resided on the unit. CNA A said they all exhibit behaviors and required assistance with activities of daily living. She said the unit was staffed with one CNA. CNA A said one CNA could not provide the required care, supervision and monitor residents for behaviors. During an interview on 05/14/14 at 1:00 p.m., CNA B said he worked on the men ' s secure unit where Resident #2 resided. He said she was not aware Resident #2 spilled coffee on himself or if any preventative measures put into place. He said the unit had 12 residents who exhibited behaviors and required assistance with activities of daily living. He said the unit was staffed with one CNA. CNA B said one CNA could not provide the required care, supervision and monitor residents for behaviors. During interviews on 05/14/14 at 1:35 p.m., LVN D said she was assigned to the men ' s secure unit where Resident #2 resided. She said she was not aware Resident #2 spilled coffee on himself until today and was unsure if preventative measures were implemented. She said she did not remain on the hall because she was also assigned other halls. She said the unit had 12 residents who exhibited behaviors and required assistance with activities of daily living. LVN D said the unit was staffed with one CNA. LVN D said one CNA could not provide the required care, supervision and monitor residents for behaviors. During an interview on 05/14/14 at 3:00 p.m., the DON said Resident #2 was not evaluated for hot beverage safety. The DON said none of the residents in the facility had been assessed. She said most residents on the secured unit had a [DIAGNOSES REDACTED]. The DON said the facility identified a need for increased staff on the secure unit, but had not implemented additional staff. Facility policy titled Resident Safety with Hot Beverages, dated 04/04/12, indicated .Skin on the arms and legs can suffer a burn before the danger is realized. The elderly who are immobilized in a wheelchair and confused residents are more susceptible. Because of this susceptibility follow the following safety precautions.residents should be supervised while drinking hot beverages, a staff member should pour the hot beverages. When serving hot liquids to residents with behavioral or medical conditions that put them at risk for spills, consider the following.evaluate resident's ability to independently manage hot beverages and provide appropriate assistance. During an interview on 05/14/14 at 3:00 p.m., the DON said 12 residents resided on the male secured unit