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 _____	08/03/2020

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 0550 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the right to be free from involuntary seclusion was provided for 1 of 5 residents reviewed for Resident Rights. (Resident #1). The facility failed to protect Resident #1 rights to be free of involuntary seclusion . Resident #1 was placed on the secured/locked unit without clinical justification. The resident was accused of inappropriately touching Resident #2 who slapped Resident #1's face. The facility gave Resident #1 an ultimatum to either be placed on the secure unit or be discharged . This failure could place residents at risk for having rights violated, feeling isolated, low self-esteem and depression. Findings included: An undated face sheet indicated Resident #1 was [AGE] years old and was admitted on [DATE]. His [DIAGNOSES REDACTED]. An MDS dated [DATE] indicated Resident #1 had moderate cognitive impairment and required supervision with ADLs. The MDS indicated Resident #1 rejected care, but he had no physical, verbal or other behaviors directed towards others and he did not display wandering behaviors. The MDS further indicated he did not show any signs of feeling down, depressed or hopeless. The most recent MDS dated [DATE] indicated he was feeling down, depressed, or hopeless several days. A care plan dated 07/20/20, initiated on 01/31/20, did not indicated Resident #1 had inappropriate behaviors or required placement on the secured unit. A care plan dated 07/20/20, initiated on 7/18/20, indicated Resident #1 was hit in the face by another resident. The nurse separated the residents and Resident #1 was removed from situation. Interventions included to assess and treat accordingly. A care plan dated 07/20/20 with a start date of 07/18/20 indicated Resident #1 denied grabbing other resident/girlfriend's bottom as they went to smoke. Interventions included were to refer Resident #1 to social services, separate him from the general population and female resident in question. A care plan dated 07/21/20 indicated Resident #1 was moved to the secured unit to detour interaction with a female resident. It indicated Resident #1 willingly agreed to move to the unit after the social worker spoke with him about the event with his girlfriend. Interventions included to place Resident #1 in the secured all male unit, refer to social worker and psychiatric services as needed. Physician orders [REDACTED].#1 of Resident #2's allegation of him slapping her on her bottom without her consent. The note indicated the resident was given the choice of either move to the secure unit or be discharged to another facility. The note indicated Resident #1 stated I didn't do anything. An electronic note progress note dated 07/20/20 at 10:40 a.m., written by the DON, indicated Resident #1 had been on 1:1 supervision since the incident. The note indicated Resident #1 continued to state, I did not do anything. An initial psychiatric evaluation dated 07/23/20, written by NP H, indicated Resident #1 was seen for agitation, aggressive behaviors, anxiety, depression/sadness, high risk behavior, sexual inappropriate behavior, and a physical altercation with Resident #2 reported by the facility administration. The document indicated staff reported they witnessed Resident #2 slap Resident #1 but did not witness the supposed sexually inappropriate behavior that led to altercation. The document indicated Resident #1 said he did not do what they said he did. During an observation and interview on 08/03/20 at 10:40 a.m., Resident #1 was sitting in his wheelchair in his room on the secure unit. When the surveyor entered Resident #1's room he asked, Are you here to see if I can go back to my room out there? Resident #1 said he was placed on the secure unit after being involved in an incident with Resident #2. He said while he was sitting in his wheelchair against the wall (on the general population hall) Resident #2 walked up and slapped him on the face for no reason. He said he and Resident #2 were good friends and had never had any type of sexual relationship. He said he had not touched Resident #2. He said the social worker and DON told him he had to stay on the secure unit or they would send him to another facility. He said he felt he was locked up for no reason and he was being punished for something he did not do. He said he liked being at the facility and did not want to leave. The resident said he felt he did not have a choice about being locked on the secured unit if he wanted to stay at the facility. He said since he was moved to the secured unit he felt down, depressed, and did not want to be on the locked unit because he felt like a prisoner. He said the social worker and DON told him he would have to stay on the secure unit until the State came in and investigated the incident to determine if it was okay for him to come off the unit. Resident #1 said I really hope you can help me, I don't want to be locked up. During an interview on 08/03/20 at 10:25 a.m., the DON said Resident #2 accused Resident #1 of hitting her on the bottom. She said Resident #1 was told he could go to the secure unit or other placement would be found for him, so he agreed to go to the secure unit. During an interview on 08/03/20 at 10:50 a.m. CNA C said he assisted Resident #1 with ADL care before he was moved on the secure unit and while on the secure unit. CNA C said to his knowledge Resident #1 had never had any behaviors. CNA C said Resident #1 would stay in his room a lot on the open unit but would socialize with other residents. He said he had noticed since Resident #1 was on the secure unit he always stayed in his room and did not socialize with other residents. He said Resident #1's mood seemed down since he had been on the secure unit. During an observation and interview on 08/03/20 at 12:00 p.m., Resident #1 sat in his wheelchair in front of his TV with his eyes closed. When the surveyor entered Resident #1's room he asked, Have a decision been made yet to let me out? Resident #1 said before he was moved to the secure unit he would go out of his room and talk to other residents. He said he had no one to talk to on the unit but staff, so he would just sit in his room and watch TV. Resident #1 said he had been feeling more down and he worried daily about when he would be able to go back to his room on the open floor. He said he felt like he was in prison and could not move around freely all because of something he did not do. During an interview on 08/03/20 at 12:30 p.m., the DON said there was no order written for Resident #1 to be on the secure unit. She said she talked with NP D and she had given the order on 07/20/20, but she could not find where she had written the order. During an interview on 08/03/20 at 12:38 p.m., LVN E said she worked the day Resident #1 was moved to the secure unit. She said she did not notify the physician and she was not told to write an order to move Resident #1 to the secured unit. An undated face sheet indicated Resident #2 readmitted [DATE] from a behavioral hospital. She was 54-years-old with [DIAGNOSES REDACTED]. The most recent MDS dated [DATE] indicated Resident #2 had moderate cognitive impairment and required supervision with all activities of daily living. The MDS indicated Resident #2 had no physical, verbal or other behaviors directed towards others. A care plan dated 07/21/20 indicated Resident #2 had repetitive behaviors with male residents. It indicated Resident #2 led male residents to believe she was interested in them sexually and then when she became upset over anything, she accused them of inappropriate behaviors directed towards her. Interventions included redirect as needed by referring to social worker and psychiatric services as needed. A care plan dated 10/11/18 and reviewed on 07/22/20 indicated Resident #2 had a history of [REDACTED].#2, refer to social services, and report behaviors to physician as needed. A care plan dated 07/18/20 indicated Resident #2 was physically aggressive towards other residents. Interventions included encourage resident to speak to staff instead of being aggressive towards other residents. During an interview on 08/03/20 at 11:30 a.m., Resident #2 said she slapped Resident #1. During an interview on 08/03/20 at 6:45 p.m. RN B said she worked the night of the incident. She said Resident #1 was sitting in his wheelchair appropriately 8-10 feet from Resident #2. RN B said it would have been impossible for Resident #1

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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 1) to have touched her at that time because he was not near her. During an interview on 08/03/20/ at 10:20 a.m., the administrator said on 07/18/20 Resident #2 accused Resident #1 of hitting her on the bottom. She said Resident #1 was placed on the male secured unit after the IT meeting on 07/20/20 because she felt that was the only way to keep Resident #1 away from Resident #2 and she wanted to make sure Resident #2 was protected. She said Resident #1 was told he would have to stay on the secured unit until the State agency investigated the incident. She felt it was okay to put Resident #1 on the secured unit to protect Resident #2. During an interview on 08/03/20 at 11:12 a.m. the social worker said Resident #1 and Resident #2 had an incident on 07/18/20 and Resident #2 hit Resident #1 because she said he had touch her on the bottom. She said Resident #1 had not displayed any inappropriate sexual behaviors or other behaviors since she started to work at the facility in 2017. She said Resident #2 had behaviors of attention seeking, refusing medications, and having sex with other male residents. She said since Resident #2 slapped Resident #1 because he allegedly touched her bottom without her permission, Resident #1 was relocated. She said Resident #1 denied the allegation. She said although the allegation could not be proven, Resident #1 was given the option to go to the secured unit or to another facility. She said Resident #1 was not put on the secured unit because of behaviors or risk for elopement, but to not have access to Resident #2. During an interview on 08/03/20 at 12:50 p.m. CNA F said she had never witnessed Resident #1 have any behaviors or touch anyone inappropriately. She said Resident #1 seemed more down and depressed and withdrawn since being on the secured unit. She said Resident #1 would always talk with her, but now he will only say he does not want to be locked up. During an interview on 08/03/20 at 2:37 p.m. the DON said Resident #1 did not have a signed a consent to be on the secured unit. She said they did not try any less restrictive measures. During an interview on 08/03/20 at 3:48 p.m. the administrator said she was the abuse coordinator. She said it was her policy to place a resident on the secured unit to protect another resident if an allegation of sexual aggression was made. She said it did not matter if the allegation could not be proven. The policy for admission criteria to the secured unit dated 04/2020 indicated: POLICY: Only individuals having [MEDICAL CONDITION], organic irreversible dementia and residents with exit-seeking and wandering behaviors will be considered appropriate for this unit. Some residents that exhibit [MEDICAL CONDITION] and would benefit from a more structures, serene environment will also be considered for the Unit. Facilities may designate male only, female only or mixed gender secured units. Secure Unit Placement Criteria: General Criteria Guidance: Residents with progressive, irreversible dementia vary in their physical and behavioral needs and may not require secure unit placement. Living on the secured unit should be the least restrictive course of action in that it allows the resident free movement. Placement on the unit is not intended for punishment or staff convenience. Placement Criteria: 1. Individuals referred for admission to the secured unit will have the following information available prior to or completed as part of the admission process: A recent History and Physical describing the medical rational for cognitive decline Brief Interview Mental Status (B.I.M.S.) SLP Pre-Placement Evaluation Recent Routine Laboratory Test 2. Documented evidence justifying placement on Secured Unit: The potential resident exhibits wandering/exit seeking or other behaviors that places the resident in danger or potential danger. The potential resident exhibits wandering/exit seeking or other behaviors that place others in danger. The potential resident has significant behavioral symptoms that disrupt the rights or of others. 3. and in all cases: Less restrictive alternatives have been unsuccessful. Legal authority has been established. Documentation Requirements upon Admission to Secured Unit: 1. Physician order [REDACTED]. 2. Development of a Care Plan identifying need for secure unit placement individualized to meet the resident's specific needs. 3. The Interdisciplinary Team will evaluate and document quarterly that the resident continues to meet criteria for placement on secured unit . According to the Resident Rights policy provided by the facility dated 12/2016 1. Federal and state laws guarantee certain basic rights to all residents of this facility . These rights include the resident's right to : d. be free of corporal punishment or involuntary seclusion, and physical or chemical restraints not required to treat the residents symptoms:
F 0603 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Protect each resident from separation (from other residents, his/her room, or confinement to his/her room).** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the right to be free from involuntary seclusion was provided for 1 of 5 residents reviewed for abuse. (Resident #1). The facility did not prevent Resident #1 from being involuntarily secluded. Resident #1 was placed on the secured/locked unit without clinical justification. The resident was accused of inappropriately touching Resident #2 who slapped Resident #1's face. The facility gave Resident #1 an ultimatum to either be placed on the secure unit or be discharged . This failure could place residents at risk for retaliation, feeling isolated, low self-esteem and depression. Findings included: An undated face sheet indicated Resident #1 was [AGE] years old and was admitted on [DATE]. His [DIAGNOSES REDACTED]. An MDS dated [DATE] indicated Resident #1 had moderate cognitive impairment and required supervision with ADLs. The MDS indicated Resident #1 rejected care, but he had no physical, verbal or other behaviors directed towards others and he did not display wandering behaviors. The MDS further indicated he did not show any signs of feeling down, depressed or hopeless. The most recent MDS dated [DATE] indicated he was feeling down, depressed, or hopeless several days. A care plan dated 07/20/20, initiated on 01/31/20, did not indicate Resident #1 had any behaviors or resided on the secure unit. A care plan dated 07/20/20, initiated on 7/18/20, indicated Resident #1 was sitting in his wheelchair another resident charged towards him and hit him in the face. The nurse separated the residents and Resident #1 was removed from situation. Interventions included to assess and treat accordingly. A care plan dated 07/20/20 with a start date of 07/18/20 indicated Resident #1 denied grabbing other resident/girlfriend's bottom as they went to smoke. Interventions included were to refer Resident #1 to social services, separate him from the general population and female resident in question. A care plan dated 07/21/20 indicated Resident #1 was moved to the secured unit to detour interaction with a female resident. It indicated Resident #1 willingly agreed to move to the unit after the social worker spoke with him about the event with his girlfriend. Interventions included to place Resident #1 in the secured all male unit, refer to social worker and psychiatric services as needed. Physician orders [REDACTED].#1 of Resident #2's allegation of him slapping her on her bottom without her consent. The note indicated the resident was given the choice of either move to the secure unit or be discharged to another facility. The note indicated Resident #1 stated I didn't do anything. According to the note, Resident #1 understood and agreed that he did not want to move to another facility by nodding his head. An electronic note progress note dated 07/20/20 at 10:40 a.m., written by the DON, indicated Resident #1 had been on 1:1 supervision since the incident. The note indicated Resident #1 continued to state, I did not do anything. An electronic note dated 07/20/20 at 2:26 p.m., written by LVN E indicated Resident choose to move into the men's secure unit. An initial psychiatric evaluation dated 07/23/20, written by NP H, indicated Resident #1 was seen for agitation, aggressive behaviors, anxiety, depression/sadness, high risk behavior, sexual inappropriate behavior, and a physical altercation with Resident #2 reported by the facility administration. The document indicated staff reported they witnessed Resident #2 slap Resident #1 but did not witness the supposed sexually inappropriate behavior that led to altercation. The document indicated Resident #1 said he did not do what they said he did. During an observation and interview on 08/03/20 at 10:40 a.m., Resident #1 was sitting in his wheelchair in his room on the secure unit. When the surveyor entered Resident #1's room he asked, Are you here to see if I can go back to my room out there? Resident #1 said he was placed on the secure unit after being involved in an incident with Resident #2. He said while he was sitting in his wheelchair against the wall (on the general population hall) Resident #2 walked up and slapped him on the face for no reason. He said he had not touched Resident #2. He said the social worker and DON told him he had to stay on the secure unit or they would send him to another facility. He said he felt he was locked up for no reason and he was being punished for something he did not do. He said he liked being at the facility and did not want to leave. The resident said he felt he did not have a choice about being locked on the secured unit if he wanted to stay at the facility. He said since he was moved to the secured unit he felt down, depressed, and did not want to be on the locked unit because he felt like a prisoner. He said the social worker and DON told him he would have to stay on the secure unit until the State came in and investigated the incident to determine if it was okay for him to come off the unit. Resident #1 said I really hope you can help me, I don't want to be locked up. During an interview on 08/03/20 at 10:25 a.m., the DON said Resident #2 accused Resident #1 of hitting her on the bottom. She said both residents were put on 1:1 supervision. She said staff who were supervising the residents during the smoke break were interviewed and no staff witnessed Resident #1 hit Resident #2's bottom. Staff reported the residents were not near each other during the break. She said Resident #1 was told he could go to the secure unit or other placement would be found for him, so he agreed to go to the secure unit. The DON said Resident

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F 0603 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 2) #1 had no behaviors, Resident #2 had a history of [REDACTED].#1 with ADL care before he was moved on the secure unit and while on the secure unit. CNA C said to his knowledge Resident #1 had never had any behaviors. CNA C said Resident #1 would stay in his room a lot on the open unit but would socialize with other residents. He said he had noticed since Resident #1 was on the secure unit he always stayed in his room and did not socialize with other residents. He said Resident #1's mood seemed down since he had been on the secure unit. During an observation and interview on 08/03/20 at 12:00 p.m., Resident #1 sat in his wheelchair in front of his TV with his eyes closed. When the surveyor entered Resident #1's room he asked, Have a decision been made yet to let me out? Resident #1 said before he was moved to the secure unit he would go out of his room and talk to other residents. He said he had no one to talk to on the unit but staff, so he would just sit in his room and watch TV. Resident #1 said he felt down and he worried daily about when he would be able to go back to his room on the open floor. He said he felt like he was in prison and could not move around freely all because of something he did not do. During an interview on 08/03/20 at 12:30 p.m., the DON said there was no order written for Resident #1 to be placed on the secure unit. She said she talked with NP D and she had given the order on 07/20/20, but she could not find where the order was written. During an interview on 08/03/20 at 12:38 p.m., LVN E said she worked the day Resident #1 was moved to the secure unit. She said she was told by the DON, Resident #1 would be moving to the secured unit. She said she was never told why he was moved to the unit, but she heard about the incident. She said she did not notify the physician and she was not told to write an order to move Resident #1 to the secured unit. She had never witnessed Resident #1 touch Resident #2 at any time. An undated face sheet indicated Resident #2 readmitted [DATE] from a behavioral hospital. She was 54-years-old with [DIAGNOSES REDACTED]. The most recent MDS dated [DATE] indicated Resident #2 had moderate cognitive impairment and required supervision with all activities of daily living. The MDS indicated Resident #2 had no physical, verbal or other behaviors directed towards others. A care plan dated 07/21/20 indicated Resident #2 had repetitive behaviors with male residents. It indicated Resident #2 led male residents to believe she was interested in them sexually and then when she became upset over anything, she accused them of inappropriate behaviors directed towards her. Interventions included redirect as needed by referring to social worker and psychiatric services as needed. A care plan dated 10/11/18 and reviewed on 07/22/20 indicated Resident #2 had a history of [REDACTED].#2, refer to social services, and report behaviors to physician as needed. A care plan dated 07/18/20 indicated Resident #2 was physically aggressive towards other residents. Interventions included encourage resident to speak to staff instead of being aggressive towards other residents. During an interview on 08/03/20 at 11:30 a.m., Resident #2 said she slapped Resident #1. During an interview on 08/03/20 at 6:45 p.m. RN B said she worked the night of the incident. She said Resident #1 was sitting in his wheelchair appropriately 8-10 feet from Resident #2. RN B said it would have been impossible for Resident #1 to have touched Resident #2 because he was not near her. During an interview on 08/03/20/ at 10:20 a.m., the administrator said on 07/18/20 Resident #2 accused Resident #1 of hitting her on the bottom. She said Resident #1 was placed on the male secured unit after the IT meeting on 07/20/20 because she wanted to make sure Resident #2 was protected. She said she felt that was the only way to keep Resident #1 away from Resident #2. She said Resident #1 was told he would have to stay on the secured unit until the State agency investigated the incident. During an interview on 08/03/20 at 11:12 a.m. the social worker said Resident #1 and Resident #2 had an incident on 07/18/20 and Resident #2 hit Resident #1 because she said he had touch her on the bottom. She said Resident #1 had not displayed any inappropriate sexual behaviors or other behaviors since she started to work at the facility in 2017. She said Resident #2 had behaviors of attention seeking, refusing medications, and having sex with other male residents. She said since Resident #2 alleged Resident #1 touched her bottom without her permission, Resident #1 was relocated. She said Resident #1 denied the allegation and said the two of them were just friends. She said the allegation could not be proven. Resident #1 was given the option to go to the secured unit or to another facility. She said Resident #1 was not put on the secured unit because of behaviors or risk for elopement, but to not have access to Resident #2. During an interview on 08/03/20 at 12:50 p.m. CNA F said Resident #1 seemed more down and depressed and withdrawn since being on the secured unit. She said Resident #1 would always talk with her, but now he will only say he does not want to be locked up. During an interview on 08/03/20 at 2:37 p.m. the DON said Resident #1 did not have a signed a consent to be on the secured unit. They were waiting for the state agency to come and investigated. She said he was put on the unit to protect the person whom had made the allegation. She said he was to remain on the unit for as long as it took for the State Agency to come. She said the facility did not try any less restrictive measures even though Resident #1 had never displayed any inappropriate sexual behaviors. During an interview on 08/03/20 at 3:48 p.m. the administrator said she was the abuse coordinator. She said it was her policy to place a resident on the secured unit to protect the another resident if an allegation of sexual aggression was made. She said it did not matter if the allegation could not be proven, she was protecting Resident #2 because the allegation had been made. The policy for admission criteria to the secured unit dated 04/2020 indicated: POLICY: Only individuals having [MEDICAL CONDITION], organic irreversible dementia and residents with exit-seeking and wandering behaviors will be considered appropriate for this unit. Some residents that exhibit [MEDICAL CONDITION] and would benefit from a more structures, serene environment will also be considered for the Unit. Facilities may designate male only, female only or mixed gender secured units. Secure Unit Placement Criteria: General Criteria Guidance: Residents with progressive, irreversible dementia vary in their physical and behavioral needs and may not require secure unit placement. Living on the secured unit should be the least restrictive course of action in that it allows the resident free movement. Placement on the unit is not intended for punishment or staff convenience. Placement Criteria: 1. Individuals referred for admission to the secured unit will have the following information available prior to or completed as part of the admission process: A recent History and Physical describing the medical rational for cognitive decline Brief Interview Mental Status (B.I.M.S.) SLP Pre-Placement Evaluation Recent Routine Laboratory Test 2. Documented evidence justifying placement on Secured Unit: The potential resident exhibits wandering/exit seeking or other behaviors that places the resident in danger or potential danger. The potential resident exhibits wandering/exit seeking or other behaviors that place others in danger. The potential resident has significant behavioral symptoms that disrupt the rights or of others. 3. and in all cases: Less restrictive alternatives have been unsuccessful. Legal authority has been established. Documentation Requirements upon Admission to Secured Unit: 1. Physician order [REDACTED]. 2. Development of a Care Plan identifying need for secure unit placement individualized to meet the resident's specific needs. 3. The Interdisciplinary Team will evaluate and document quarterly that the resident continues to meet criteria for placement on secured unit . The abuse policy dated 05/2020 indicated: .2. Our resident have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual and physical or chemical restrained not required to treat the resident's symptoms .