STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675021	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Electra Healthcare Center	511 S Bailey St Electra, TX 76360

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41871 Based on interview and record review, the facility failed to include resident or the resident's representative in the IDT (Interdisciplinary team) in the comprehensive care planning within 7 days after completion of the comprehensive assessment for 2 of 4 residents (Resident #8 and Resident #10) reviewed for care plan timing/revision. The facility failed to ensure Resident #8 and Resident #10's care plan was reviewed by the IDT (Interdisciplinary team), which failed to include the resident or the resident's representative after the Comprehensive MDS assessment. This failure placed the residents at risk for not having individual needs identified and care and services provided to meet their needs and promote quality of care, feelings of well-being and quality of life. The findings included: Resident #8 A record review of Resident #8's Admission Record, dated 01/07/2025 revealed Resident #8 had an admitted [DATE]. Resident #8's had a primary diagnosis was unspecified dementia (a group of symptoms affecting memory, thinking and social abilities). A record review of the Resident #8's Quarterly MDS assessment, dated 12/12/2024, revealed a BIMS score of 00, which means the resident was severely impaired. A record review of Resident #8's comprehensive care plan revealed it was last Reviewed/Revised on 01/05/2025. There was no documented evidence that a care plan meeting was conducted for this care plan. A record review of Resident #8's progress notes revealed there was not a care plan meeting conducted since admission on 10/10/2024. In an interview with Resident #8 on 01/05/2025 at 10:25 am, he failed to answer if he had been invited or had participated in a care plan meeting. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #10 A record review of Resident #10's Admission Record, dated 01/07/2025, revealed Resident #10 was a [AGE] year-old male/female who had an admitted [DATE]. Resident #10 had a primary diagnosis of Infection following a procedure, deep incisional surgical site, and Major Depressive Disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). A record review of the Resident #10's Admission MDS assessment, dated 12/18/2024, revealed a BIMS score of 15, which means the resident was cognitively intact. A record review of Resident #10's comprehensive care plan revealed it was last Reviewed/Revised on 01/05/2025. There was no documented evidence that a care plan meeting was conducted for this care plan. A record review of Resident #10's progress notes revealed there was not a care plan meeting conducted since admission on 12/06/2024. In an interview with Resident #10 on 01/05/2025 at 1:36 pm, she said she had not been invited or had participated in a care plan meeting. In an interview with the DON on 01/07/2024 at 11:17 am, she said she was responsible for scheduling the care plan meetings. She said there was no documentation of a care plan meeting or that she can remember having a care plan meeting for Resident #8 since admission. The DON said she attempted to contact Resident #10's family for a care plan meeting and they never responded. She said it got pushed back due to the holiday activities. The DON said potential negative outcomes of not including the resident or their representative in a care plan meeting would be the resident or representative would not understand the care they were receiving, and the facility wouldn't know of resident's needs. A record review of the facility policy Care Planning - Interdisciplinary Team, dated as revised March 2022, revealed the following [in part]: Policy Statement: The Interdisciplinary Team is responsible for the development of resident care plans. Policy Interpretation and Implementation: 2. Comprehensive, person-centered care plans are based on resident assessments and developed by an Interdisciplinary Team (IDT). 3. The IDT includes but is not limited to: e. to the extent practicable, the resident and/or resident's representative. 6. If it is determined that participation of the resident or representative is not practicable for development of the care plan, an explanation is documented in the medical record.