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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 26221 Based on interview and record review the facility failed to develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents for 3 of 6 (DON, DM, SW) staff reviewed for abuse protocol. The facility failed to complete annual Criminal Background Checks for the DON, DM, and SW. This failure could place residents at risk for abuse, neglect, and exploitation. Findings included: Record review of the DON's personnel file revealed no annual criminal background check completed since 07/03/2012. The DON had a hire date of 07/09/2012. Record review of the DM's personnel file revealed no criminal background check completed previously. The DM had a hire date of 11/06/1995. Record review of the SW's personnel file revealed no criminal background check completed previously. The SW had a hire date of 10/06/2008. In an interview on 01/07/25 at 04:45 PM, the CSM stated she was the staff member responsible for completing all background checks and that she did the DON, DM, and SW background checks on 1/7/25. She said when she pulled staff records for the survey, she realized they had not been done. CSM stated, I did not realize background checks are required on every staff member. I also did not know that background checks are required annually. Record review of the facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy (revised 04/2021) read in part Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, facility staff . Conduct employee background checks and not knowingly employ or otherwise engage any individual who has: been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law.

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

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41871 Based on interview and record review, the facility failed to ensure all Preadmission Screening and Resident Review (PASARR) Level I (PL1) Screening residents diagnosed with mental illness were provided with a PASARR Level II (PE) Screening for 2 of 3 residents (Resident #10 and Resident #15) reviewed for a mental illness, intellectual disability, or developmental disability. The facility failed to ensure Resident #10 and #15 who had a diagnosis of mental illness had a PASARR Level II (PE) screening completed. This failure placed residents at risk of mental health needs not being met. The findings included: Resident #10 A record review of Resident #10's Admission Record, dated 01/07/2025, revealed Resident #10 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 a PASARR Level I (PL1) Screening, dated 12/04/2024, indicated Resident #10 had no evidence of mental illness. No PASARR Level II (PE) Screening or a form 1012 (Mental Illness/Dementia Resident Review) was found in the clinical record. A record review of the Resident #10's Admission MDS assessment, dated 12/18/2024, revealed Active Diagnosis of Depression. The resident had a BIMS score of 15 which indicates the resident was cognitively intact. A record review of Resident # 10's Care Plan, with a revision date of 12/17/2024, indicated Resident #10 may develop Impaired coping related to diagnosis of Major Depressive Disorder. A record review of Resident #10's Physician Order Summary Report, dated 01/07/2025, indicated Resident #10 received duloxetine 90mg daily for diagnosis of Major Depressive Disorder. Resident #15 A record review of Resident #15's Admission Record, dated 01/07/2025, revealed Resident #15 had an admitted [DATE]. Resident #15 had a primary diagnosis Parkinson's Disease (a neurodegenerative disease primarily of the central nervous system, affecting both motor and non-motor systems), Major Depressive Disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety disorder (a group of mental disorders characterized by significant and uncontrollable feelings of anxiety and fear such that a person's social, occupational, and personal functions are significantly impaired). (continued on next page)

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of the Resident # 15's Admission MDS assessment, dated 11/22/2024, revealed Active Diagnosis of Anxiety Disorder and Depression. The resident had a BIMS score of 15 which indicates the resident was cognitively intact. A record review of a PASARR Level I (PL1) Screening, dated 11/15/2024, indicated Resident #15 had no evidence of mental illness. No PASARR Level II (PE) Screening or a form 1012 (Mental Illness/Dementia Resident Review) was found in the clinical record. A record review of Resident # 15's Care Plan, with a revision date of 01/05/2025, indicated Resident #15 has depression related to disease process (Parkinson's). A record review of Resident #15's Physician Order Summary Report, dated 01/07/2025, indicated Resident #15 received sertraline 100mg daily for diagnosis of Major Depressive Disorder. In an interview on 01/07/2025 at 11:23 am, the DON stated the Social Worker was responsible for updating the PASARR's. She did not know a PASARR needed to be updated when they came from the hospital. She said a potential failure would be the resident would not receive services they would be eligible for. In an interview on 01/07/2025 at 2:04 pm, the Social Worker said she was responsible for PASARR's. She said Resident #10 and Resident #15 should have a new PASARR (PL1) screening completed due to having a diagnosis of Major Depressive Disorder but was not aware the residents had a diagnosis of a mental illness. She said a potential negative outcome of this failure would be a resident might not receive PASSAR services if they were eligible. Record review of the facility policy Admission Criteria, dated as last revised March 2019, revealed the following [in part]: Policy Interpretation and Implementation: 9. All new admission and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASAR) process. a. The facility conducts a Level I PASARR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for MD, ID or RD. b. If the Level 1 screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process.

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41871 51011 Based on interview and record review the facility failed to develop and implement a comprehensive, person-centered care plan for each resident that included measurable objectives and time frames to meet, attain, and/or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 14 residents (Residents #120) reviewed for care plans. The facility failed to have a care plan for Resident #120's Hospice status. These failures could affect residents by placing them at risk of not receiving individualized care and services to meet their needs. The findings included: Review of the most recent Minimum Data Set (MDS), dated [DATE], revealed: Resident #120 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses included stroke, Non-Alzheimer's Dementia, seizure disorder, and malnutrition. Resident #120 had a BIMS of 15 of 15 (indicating cognitively intact). Review of Resident #120's Care Plan last revised on 12/16/2024, revealed: Hospice status was not included in the care plan. Review of Resident #120's Physician Orders revealed order dated 07/31/2024: Admit to Hospice, Diagnosis Senile Dementia written by Resident #120's primary care physician. Review of Resident #120's Face Sheet revealed: Hospice Medicaid as the Primary Payer and a Hospice company as an External Facility involved in Resident #120's care. In an interview on 01/07/25 at 4:40 PM, the DON stated she was responsible for the Care Plans. The DON stated she did not realize that Hospice services needed to be care planned. The DON said she thought a hospice care plan would be necessary because so all staff are aware of the resident's needs. Record review of the facility's Care Plans, Comprehensive Person-Centered policy (revised 03/2022) read in part The comprehensive, person-centered care plan: describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .

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. 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. (continued on next page)

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	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.

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26221 Based on observation, interview, and record review the facility failed to ensure adequate supervision and assistance devices was provided for 1of 2 residents reviewed for transfers. (Resident # 119). The facility did not assess Resident #119 for use of a lift device even though he was non-weight bearing. The facility failed to ensure staff transferred Resident #119 in a manner to prevent injuries. The staff performed one-person lifts by hugging the resident or hooking their arms under his shoulders. This failure could place residents who required assistance during transfers at risk for pain and injury. Findings included: Review of Resident #119's Admission Record dated 1/7/25 revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnosis including Lowe's Syndrome (a rare genetic order that causes weak muscle tone and abnormal spine). Review of Resident #119's Quarterly MDS assessment dated [DATE] revealed: He had severely impaired decision-making skills and signs of delirium to include inattention and disorganized thinking,. He used a wheelchair, He was completely dependent on staff for all ADL's including transfers, and He weighed 93 pounds. Review of Resident #119's care plan initiated 10/19/24 revealed: Focus: The resident has an ADL self-care performance deficit. Goal: The resident will achieve maximum functional mobility. Interventions included: Transfer: The resident is totally dependent on 1 staff for transferring. Review of Resident #119's Order Summary Report, dated 1/7/25, revealed orders: Non weight bearing bilateral (both) lower extremities dated 8/4/24. Review of Resident #119's vital signs revealed Resident #119 weighed 90 pounds on 1/2/25. (continued on next page)

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #119's electronic record to include assessments and miscellaneous revealed no assessment on safe transfer ability. Interview on 1/6/25 at 1:51 p.m., CNA E stated Resident #119 was not weight bearing and was a one-person transfer. CNA E described a transfer Resident #119 as a hug, that Resident #119 would hug the staff and then the staff would just pick him up. CNA E said Resident #119 was 90 pounds if that. CNA E said Resident #119 was not weight-bearing and his feet would not touch the ground during the transfer. Observation on 1/6/25 at 4:32 p.m., CNA E locked Resident #119's wheelchair and then put Resident #119's hands on her shoulders. CNA E was observed putting her arms around Resident #119 under his arms and pulled him out of the wheelchair, pivoted, and placed Resident #119 in the bed. Resident #119 feet did not drag on the ground. Interview on 1/6/25 at 4:52 p.m., COTA G stated a safe one-person transfer would be to use a gait belt. COTA G stated the process was to put the gait belt on the resident, get the foot pedals out of the way if necessary, turn the resident's feet a little bit in the direction of the turn, have the resident put their hands on the aide's shoulder and on the count of three have the resident stand, assist to pivot and have the resident sit where they were transferring to. COTA G stated she did not think it was safe to transfer one-person if the person was non-weight bearing and the person would need some help to do it safely. COTA G stated in Resident #119's situation it would be safe because all he knew was, he wanted up at that moment and would not wait for another person to come. COTA G stated a gait-belt should be used. COTA G said if not gait belt was used the person could throw their arms up and slide out of the aide's arms and fall right out. COTA G stated she talked to the staff about transfers multiple times and the last time was right before Christmas. Interview on 1/6/25 at 5:22 p.m., the DON stated her expectation for a non-weight bearing transfer for someone like Resident #119 was he could be safely transferred one-person because he was 90 pounds. The DON said if he was having behaviors, she would expect the aides to ask for help The DON said the care plan was to pick him up and scoot him over so he does not fight the aides. The DON said alternates to the one-person transfer could be a slide-board if the wheelchair could accommodate it or a mechanical lift with a sling. Interview on 1/7/25 at 11:21 a.m. CNA F said Resident #119 had cysts on his back and the aides were afraid if they used the gait belt the cysts would be ripped open, and Resident #119 would become combative. CNA F and CNA E who was also present said Resident #119 would be appropriate for a mechanical lift transfer if someone held his hands during the transfer. Review of the facility's policy and procedure on Safe Lifting and Movement of Residents, dated 2001, revealed: In order to protect the safety and well-being of staff and residents, and to promote quality of care, this facility uses appropriate techniques and devices to lift and move residents. Policy Interpretation and Implementation: 2. Manual lifting of residents shall be eliminated when feasible. (continued on next page)

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Nursing staff, in conjunction with the rehabilitation staff, shall assess the individual residents' needs for transfer assistance on an ongoing basis. Staff will document transferring and lifting needs in the care plan. Such assistance shall include the following: Resident's mobility (degree of dependency); Resident's size; Weight-bearing ability; Cognitive status; Whether the resident is usually cooperative with staff.

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51011 Based on observation, interview and record review the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for food safety. These failures could place residents at risk of food-borne illness and a diminished quality of life. 1. The trash can at the hand sink was full, smelled of rotten food, and had a pan of individually wrapped cookies on top of the lid. 2. Staff B touched food surfaces while filling plates with food. 3. The kitchen drawers had an accumulation of food debris in the bottom. 4. The dry storage room had plastic bins that were greasy and had debris in the bottoms. 5. The freezer had chicken and ham in it with freezer burn. 6. Dietary staff had hair that was not completely covered and hand washing was not done correctly. 7. The facility failed to ensure all food in the dry pantry and cold storage areas were properly sealed, labeled and dated. 8. Dishes were stored face up (open to air contamination 9. Aluminum cans of resident juices stored on the shelf with dishwasher chemicals 10. Cans in the dry storage room are dusty and dented. 11. Single use plastic lids for cups and bowls, and plastic soup spoons are stored open to air. 12. Chemicals were stored with the food. These failures could place residents at risk of food-borne illness and a diminished quality of life. Findings included: Initial observation and interview on 1/5/25 beginning at 9:40 a.m. revealed: - The trash can at the handwashing sink was full and smelled of rotten food. On top of the trashcan lid was a cookie pan with individually wrapped cookies on it dated 1/4/25. (continued on next page)

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- By the handwashing sink was chemicals for the dishwasher stored next the resident juices. - Observation of the refrigerator revealed a pitcher of a red liquid that was unlabeled and undated. Staff A said it was fruit punch prepared on 1/4/25. There were also 3 bags of cheese left open to air. - Observation of the dry storage revealed: - storage bins holding condiments had an accumulation of grime on the outside. On the inside of the bin holding syrup was a puddle of syrup in the bottom. The other bins had an accumulation of food debris on the bottom of them. - the cans were dusty. Some of the cans were dented and mixed with undented cans. Staff A stated dented cans were not separated from undented cans and dented cans were used like undented cans. -Prepackaged coffee bags, box was left open leaving the contents open to air. - Observation of the freezer revealed freezer-burnt ham and chicken with an accumulation of ice crystal on them. - In boxes next to the freezer were open bags of plastic spoons, Styrofoam cups and lids all left open to air. Observation of the meal preparation and service on 1/6/25 beginning at 10:45 a.m. revealed: - At 11:20 a.m., Staff B rinsed with water for less than 5 seconds and put on gloves. Staff B began to plate food. Staff B touched the eating surface of every plate she served with both hands. - The two drawers holding knives and serving utensils had an accumulation of crumbs, splashes of dried liquid and dust. - Staff B, Staff C and the DM did not have effective hair restraints. Interview on 1/6/25 at 11:45 AM, the DM said eating surfaces on the plates should not be touched with either gloved or bare hands. (continued on next page)

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 1/7/25 at 10:04 AM, the DM stated the expectation of the freezer burnt food in the freezer was it was not to be served. The DM said there was no training about what to do with freezer burnt food. The DM stated about the bins in the dry storage, some cleaning has been done since the hospital took over, we still have more to go. The DM stated the cookies on top the trash can were trashed and the expectation was to not serve it. The DM said there was no training about not serving food off an unsanitary surface. The DM stated the expectation was things were not left open to air, and that should not be happening. The DM stated it was in the policy to keep sealed but she no training on it. The DM said the staff should know better than to leave dented cans in the dry storage. The DM said her expectation on dented cans was the staff were not to use them and for them to be separated from the other cans; the DM stated there was a space in her office which was accessible at all times for the dented cans. The DM said this was not in policy and did not have any training for the staff on it. The DM said her expectations was hair be covered at all times in the kitchen. The DM admitted her hairnet was not on effectively because her bangs just slipped out. The DM was informed 3 of 4 staff including the DM during the lunch observation did not have on an effective hair net. The DM said it was not in the policy and she did not have any in-services on it. The DM said the juice mixed with dishwashing chemicals was not appropriated storage and that was covered in the facility's policies. Interview on 1/7/25 at 10:25 a.m., the Administrator was informed of the kitchen observations. Record review of the facility's policy titled Food Receiving and Storage dated 11/2022, revealed the following in part: .Non-refrigerated foods, disposable dishware and napkins are stored in a designated dry storage unit which is temperature and humidity controlled, free of insects and rodents and kept clean. .Food services, or other designated staff, maintain clean and .Non-refrigerated foods, disposable dishware and napkins are stored in a designated dry storage unit. .Foods may not be stored: under other sources of contamination. : .Housekeeping personnel will empty garbage and refuse containers daily. .Foods may not be stored: in garbage rooms. .Foods may not be stored: under other sources of contamination. .Dry foods and goods are handled and stored in a manner that maintains the integrity of the packaging until they are ready to use. .All foods stored in the refrigerator or freezer are covered, labeled and dated (use by date).

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 0912 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 26221 Based on record review and interview, the facility failed to provide the required minimum of 80 square feet of space per resident in multiple occupancy rooms for 35 of 36 rooms (Rooms #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35 and 36) reviewed for square footage. The facility failed to ensure multiple-bed resident rooms had the required 80 square feet of floor space per resident for rooms 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35 and 36. This failure could place residents residing in these rooms at risk for not having adequate living space and could adversely affect residents from attaining his or her highest practicable well-being. The findings included: Interview on 1/5/25 at 10:48 a.m. the Administrator stated he was aware the facility had a room waiver granted on the 11/29/23 survey and wanted to continue to have the room waiver. Review of the facility's Form 3740 Bed Classifications, completed by the Administrator and dated 11/29/2023, revealed room numbers 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35 and 36, were included in the licensed bed capacity as double occupancy rooms. Review of the Texas Health and Human Services letter dated 6/9/22 revealed the rooms 3, 5, 8, 9, 10, 11, 12, 13, 14, 15, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, and 35 had the waiver for less square footage than required granted. In an interview on 1/7/24 at 11:42 a.m., the Administrator stated he wished to continue the room size waiver for all the rooms listed on the past Form 3762.