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	03/25/2026

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

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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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. Based on interviews and record reviews, the facility failed to maintain an effective training program for 14 (ADMN, DON, SW, AD, DM, MS, ADON, LVN A, CNA B, CMA C, TA D, CNA E, LA F, HK G) of 16 existing staff reviewed for training records . The facility failed to ensure 2 of 16 staff (CNA B, LVN A) were not trained in Fall Prevention.The facility failed to ensure 2 of 16 (ADMIN, CNA B) staff were not trained in Infection Control.The facility failed to ensure 1 of 16 (ADMIN), staff were not trained in Abuse and Neglect.The facility failed to ensure 13 of 16 (ADMIN, DON, SW, AD, DM, MS, ADON, LVN A, CMA C, CAN B, LA F, HK G, TA D.) staff were not trained in HIV.The facility failed to ensure 2 of 16 (LVN A, CNA E) staff were not trained in Restraint Reduction. These failures could place residents at risk of receiving care from incompetent/untrained staff.The findings included:Record Review of document titled Personnel Files dated 3/23/2026 on 03/24/2026 at 10:05am it was revealed required training had not been completed for the following staff in the following areas: *ADMIN with hire date of 9/30/2024 in the areas of Infection Control (10-28-2024), Abuse & Neglect (1/29/2025) and HIV (3/24/2026).*DON with hire date of 7/09/2012 in the area of HIV (3-24-2026).*SW with hire date of 10/06/2008 in the area of HIV (3-24-2026).*AD with hire date of 9/2023 in the area of HIV (3-24-2026).*DM with hire date of 12/07/2023 in the area of HIV (3-24-2026).*MS with hire date of 6/09/1997 in the area of HIV (3-24-2026).*ADON with hire date of 3/01/2022 in the area of HIV 3-24-2026).*LVN A with hire date of 6/01/2024 in the areas of Fall Prevention (8-11-2024), HIV (3-24-2026), and Restraint Reduction (3-17-2025).*CMA C with a hire date of 3/31/2025 in the area of HIV (3-24-2026).*CNA E with a hire date of 9/16/2024 in the areas of and Restraint Reduction (3-18-2025).*CNA B with a hire date of 6/01/2024 in the areas of Infection Control (6-6-2024), Fall Prevention (6-10-2024), and HIV (7-21-2024).*LA F with a hire date of 2/17/2025 in the areas of HIV (3-23-2025) and Restraint Reduction (2-17-2025).*HK G with a hire date of 6/01/2024 in the area of HIV (3-23-2025).*TA D with a hire date of 7/29/2025 in the area of HIV (3-24-2026). During an interview on 3/23/2026 at 9:10am with LVN A it was revealed she had worked there for 6 years. LVN A stated she thought her trainings were up to date, but the facility used several different computer-based training sites and it was hard to keep up with. LVN A stated she could not remember the name of the sites they used. LVN A stated they received training from in-services as well and did not know if they counted for training. LVN A stated she did not know who was monitoring the training now as the staff who had been doing it had quit. During an interview on 3/24/2026 at 7:15am with CMA C it was revealed she had worked in the facility for 1 year. CMA C stated all training courses are done online and she did not remember the name of the website. CMA C stated when she logged into the program, it would advise her which trainings were due. CMA C stated she thought she was up to date on all training. CMA C stated no staff had advised her if she had any training that was due recently. During an interview on 03/24/2026 at 10:10 AM with CCO it was revealed that the personnel files were complete to her knowledge. She stated she knew there were some training courses that had not been completed and they were out of compliance. CCO stated she had just taken over the duties of making sure education was up to date and a plan to correct the deficit had been put into place. CCO stated she was not aware HIV training was a separate training on its own and thought (continued on next page)

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

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	infection control covered that area. CCO stated it was her expectation that all staff would have appropriate training to properly care for residents. CCO stated a negative would be that staff may not be able to provide appropriate care. During an interview on 3/25/2026 at 5:02pm with DON it was revealed there were 3 staff members responsible for ensuring education was done for all staff (DON, ADON, COO). DON stated it was an oversite that HIV education was not followed up on. DON stated as soon as they realized it was an oversite; they immediately called the staff that had not done it and told them it needed to be done immediately and it was completed on 3/24/2026. DON stated a negative outcome could be staff not understanding their job duties and staff not understanding the regulations and expectations. DON stated it could have resulted in negative resident care. DON stated they were having a meeting next week (Tuesday 3/31/2026) to appoint an education staff member to avoid oversite again. During an interview on 03/25/2026 at 5:08 PM with CCO provided the facility education calendar for 2025 and the revised calendar for 2026 and stated it was updated to include HIV training and the new calendar will be implemented next week after the meeting on education for staff. CCO stated her expectation for monthly educations was that they will be assigned every month and expectation was to be completed within 3 months. CCO stated the facility does not have a policy for required trainings. CCO stated a negative outcome for training not being up to date could be reduced knowledge of resident care and proper care may not be given. In an interview on 03/25/2026 5:31 PM with ADON it was revealed she was part of the education team. ADON stated they have all seen the holes in the training requirements since filling out the personnel training form. ADON stated they will be having a meeting next week to appoint COO to education coordinator, and she was already working on a new plan. ADON stated a negative outcome would be staff not understanding how to deal with residents correctly or not educated on how to care for them properly. Record Review on 3/25/2026 at 4:46pm of document titled Healthcare Center 2025 Calendar with no date, revealed monthly education topic areas assigned to staff for completion. The document stated [in part]:January- Infection ControlFebruary- Resident Abuse PreventionMarch- RestraintsJuly- HIV EducationNovember- Fall Prevention

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure assessments accurately reflected the resident status for 1 of 15 residents (Resident #8) reviewed for Minimum Data Set (MDS) assessment accuracy. (Resident #8) The facility failed to code Resident #8's behavioral status accurately during the MDS look back period. This failure could place residents at risk of not receiving care and services to meet their needs.Findings included: Record review of Resident #8 face sheet dated 3/24/2026 indicated Resident #8 was a [AGE] year-old female initially admitted [DATE] and re-admitted [DATE] with diagnoses which included chronic obstructive pulmonary disease (progressive inflammatory lung disease), chronic respiratory failure with hypoxia (lungs cannot adequately oxygenate the blood), dependence on supplemental oxygen, atherosclerotic heart disease (narrowing of the arteries caused by plaque buildup), depression, bipolar disorder (mental health condition of fluctuating moods), pain, and anxiety. Record review of Resident #8's MDS assessment dated [DATE] indicated Resident #8's Potential Indicators of Psychosis was not checked for hallucinations or delusions nor any behavioral symptoms. Review of the most recent MDS Comprehensive assessment dated [DATE] revealed Resident #8's Potential Indicators of Psychosis was again not checked for hallucinations or delusions nor any behavioral symptoms. Record review of Resident #8's Care Plan dated with an admission date of 1/21/2026 revealed there was no care plan for hallucinations, or delusions. Record review of Resident #8's Progress Notes revealed the resident experienced behaviors, hallucinations, and/or delusions on 1/21/2026. In an interview on 03/25/2026 at 12:29pm LVN H, stated she has worked at the facility over a year, and she had interactions with Resident #8. The Resident had hallucinations since she was admitted and that most of them were of her boyfriend being in the room or frantically looking for him. She stated the resident received services with hospice due to her terminal prognosis and was on continuous supplemental oxygen. She stated the resident would take off her oxygen, become hypoxic (lack of oxygen to the brain), then she gets confused, and starts hallucinating. She further stated when a Resident had symptoms of hallucinations or delusions she would document it in the resident's chart, inform the DON, and pass along the information to the next shift coming on. She stated Resident #8 did not have these symptoms every day but that they had increased in the last couple of months. In an interview on 03/25/2026 at 12:44pm with CNA E, she stated she had worked for the facility for 2 years. She stated she was aware of Resident #8 and her hallucinations and delusions, that she had them off and on since admission. She stated they were more frequent in the last couple months. She stated the resident would yell out and when she would check on her, the resident would have taken her oxygen out of her nose, and that she would get really confused when that happened. Stated she would report to the nurse after she made sure the resident was ok. In a telephone interview on 03/25/2026 at 1:45pm with the Hospice Nurse, she stated she was Resident #8's nurse and was aware of the resident's symptoms of hallucinations and delusions. She stated the facility informs her when that happens and depending on the situation, she would come to the facility to assess the resident herself if needed but that the facility was good about informing her. In an interview on 03/25/2026 at 3:08pm with DON, she stated that it was ultimately her responsibility to make sure the MDS assessments sent to CMS were correct. She stated her expectations of the MDS assessments were that they are initiated or updated by the MDS coordinator and/or herself as scheduled or as needed, and then she would sign off on them and submit them appropriately. She stated that the process of completing the updates to a resident's assessment was to look back 7 days through all orders, physician and nurses progress notes, and labs to have a clear picture reflected in the MDS when submitted. She stated that a negative outcome could be that the resident would not have an accurate picture of his or her care and therefore incorrect reimbursements for the facility. She then stated she was aware that Resident #8 did have hallucination and delusions, and that she was notified when they happened. She also (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated that the hospice nurse was aware of these hallucinations as well. She further stated she was responsible for verifying accuracy of all MDS assessments. In an interview on 03/25/2026 at 3:29pm with the MDS, she stated she had worked at the facility for almost a year but had been working with MDS Assessments for 15 years. She stated she was responsible for completing all MDS Assessments (admissions, quarterly, significant changes, and/or corrections) with the assistance of the DON when needed. She stated she would review and pull the information from care plans, orders, progress notes, and other evaluations to get a complete assessment for the residents for the previous 7 days but doesn't remember seeing that she was or was not having these symptoms. She stated that then the DON would sign to submit them to CMS. She stated the expectation was that they were accurate, and an adverse outcome would be the facility not being reimbursed correctly for services. Review of policy titled Certifying Accuracy of the Resident Assessment dated revised November 2019 revealed [in part]:2. Any person who completes any portion of the MDS assessment, tracking form, or correction request form is required to sign the assessment certifying the accuracy of that portion of that assessment.3. The resident assessment coordinator is responsible for ensuring that an MDS assessment has been completed for each resident. Each assessment is coordinated and certified as complete by the resident assessment coordinator, who is a registered nurse.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on record review, and interviews, the facility failed to develop and implement a comprehensive care plan to reflect current condition for 1 of 2 Residents (Resident #8) reviewed for care plan accuracy, in that: Resident #8's care plan was not revised to address the residents' hallucinations and delusions. This failure could place Resident #8 at risk of not having a comprehensive plan of care to address their needs.Findings included: Record review of Resident #8 face sheet dated 3/24/2026 indicated Resident #8 was a [AGE] year-old female initially admitted [DATE] and re-admitted [DATE] with diagnoses which included chronic respiratory failure with hypoxia (lungs cannot adequately oxygenate the blood), dependence on supplemental oxygen, depression, bipolar disorder (mental health condition of fluctuating moods), pain, and anxiety. Record review of Resident #8's MDS assessment dated [DATE] indicated Resident #8's Potential Indicators of Psychosis was not checked for hallucinations or delusions nor any behavioral symptoms. Review of the most recent MDS Comprehensive assessment dated [DATE] revealed Resident #8's Potential Indicators of Psychosis was again not checked for hallucinations or delusions nor any behavioral symptoms. Record review of Resident #8's Progress Notes revealed the resident experienced behaviors, hallucinations, and/or delusions on 1/21/2026 and 2/08/2026. Record review of Resident #8's Care Plan dated with an admission date of 1/21/2026 revealed there was no care plan for hallucinations, or delusions. In an interview on 03/25/2026 at 3:18pm with DON, she stated she was ultimately responsible to make sure the resident's care plans were completed and revised accurately. She stated that it was a group effort to keep up with all the changes that need to be made with the interdisciplinary team. She stated her expectation was for the resident's care plans to be complete and accurate in a timely manner, that a negative outcome could be the resident not receiving care needed but she was not sure how these symptoms did not make it into the care plan. She further stated she was responsible for verifying accuracy of all care plans. Review of policy titled Goals and Objectives, Care Plan dated revised April 2009 revealed [in part]:Policy Statement: Care plans shall incorporate goals and objectives that lead to the resident's highest obtained level of independence.3. Care plan goals and objectives are derived from information contained in the residents' comprehensive assessment.b. are behaviorally stated.4. Goals and objectives are entered into the resident's care plan so that all disciplines have access to such information and are able to report whether or not the desired outcomes are being achieved. Review of policy titled Care Plans, Comprehensive Person-Centered dated revised March 2022 revealed [in part]:Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident.2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MSD assessment (admission, annual, or significant change in status), and no more than 21 days after admission.7. The comprehensive, person-centered care plan:b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Review of policy titled Care Plans, Baseline dated revised March 2022 revealed [in part]:9. Care plan interventions are chosen only after gathering data, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making.11. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents conditions change.

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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. 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 27 of 31 rooms (Room #s 3, 5, 8, 9, 10, 11, 12, 13, 14, 15, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 33, 34, and 35) 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 room #s 3, 5, 8, 9, 10, 11, 12,13, 14, 15, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 34, and 35. 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: Review of the facility's Form 3740 Bed Classifications, completed by the Administrator and dated 03/25/2026, revealed room numbers 3, 5, 8, 9, 10, 11, 12,13, 14, 15, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 33, 34, and 35 were included in the licensed bed capacity as double occupancy rooms. In an interview on 3/24/26 at 9:02 AM, the Administrator stated he wanted to continue the room size waiver for all the rooms listed on the Bed Classification form and Notification of Change letter.