

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455936	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/14/2026
NAME OF PROVIDER OR SUPPLIER Focused Care at Lamesa		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 N 15th St Lamesa, TX 79331	
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 - 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 interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that were identified in the comprehensive assessment for 1 (Residents #1) of 5 residents reviewed for care plans. The facility failed to develop a care plan for use of a Wander Guard electronic signaling device, utilized for wander-management, for Resident #1. This failure could place residents at risk of not receiving the care required to meet their individualized needs. Record review of the admission record for Resident #1, dated 04/14/26, revealed an [AGE] year-old male who was admitted to the facility on [DATE] with the following diagnoses: dementia without psychosis, history of falling, unsteadiness on feet, and weakness. Record review of the quarterly MDS assessment for Resident #1, dated 01/23/26, revealed Resident #1 had a BIMS score of 05 indicating he had severe cognitive impairment. Record review of the comprehensive care plan for Resident #1, last reviewed on 03/25/26, revealed no care plan for the use of the Wander Guard electronic signaling device. During an initial interview on 04/14/26 at 11:05 AM, the ADM stated Resident #1 had a Wander Guard signaling device placed on his person fairly soon after admission due to the resident being new to the facility, being independently ambulatory, and not looking like a resident. She stated the wandering device was placed for his protection and so that a visitor would not mistakenly allow him to leave the facility. During an initial interview on 04/14/26 at 12:16 PM, the DON stated Resident #1 became more agitated with his placement after being in the facility for a couple of weeks and realizing his placement was not short-term. She stated the FNP was made aware of the resident's agitation, and she gave a verbal order to the DON for medication to help with agitation and also gave an order to place the Wander Guard signaling device for the resident's protection, until he adjusted to placement in the facility and could be re-evaluated. The DON did not recall the exact date of the verbal order, but stated it was within a week or two of admission. During a telephone interview on 04/14/26 at 1:28 PM, the FNP for Resident #1 stated she provided psychiatric services for the resident. She stated she gave a verbal order to the DON for the Resident #1 to have a Wander Guard signaling device placed due to the resident being in an adjustment phase of his long-term care placement, having a diagnosis of dementia, and being independently ambulatory. She stated she did not usually notate wander-management device placement in her notes, and she did not recall the exact date the verbal order for the signaling device was given. The FNP stated she believed the verbal order was given around the first week of December. During a telephone interview on 04/14/26 at 1:43 PM, Family Member for Resident #1 stated they were asked by facility administration if they felt a wander-management device was needed for Resident #1 on the day he was admitted to the facility. Family Member stated they did not feel it was necessary at the time of admission, but the resident did not adjust to placement right away and they felt it was a good idea to place the device after a few weeks in the facility. Family Member stated they did not observe the device on Resident #1 but was aware it was in place. During an interview on 04/14/26 at 4:26 PM, LVN A stated Resident #1 wore a (continued on next page)		

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
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Wander Guard device on his ankle. She stated she believed it was placed a week or so after the resident's admission to the facility. LVN A stated wander-management devices were usually a part of the resident care plan so staff would know the device should be placed on the resident. She stated she did not recall if Resident #1's care plan included the use of a signaling device for wandering. LVN A stated the care plan was used by all staff as an information guide for the residents' specific needs and plan of care. During a follow-up interview on 04/14/26 at 4:53 PM, the DON stated she was not aware Resident #1's care plan did not include the use of the Wander Guard device. She stated she was responsible for assuring the care plan for Resident #1 was updated because she had taken the verbal order for the device and failed to add it to the care plan. She stated the MDS coordinator usually updated the care plan but would not have known to update the care plan due to the verbal order being given to the DON and the DON not passing the information on to the MDS coordinator. The DON stated she just missed adding the information to the care plan and passing on the information to the MDS coordinator. She stated, I should have done it as soon as I took the order. She stated the care plan was used by all direct care staff for a resident's specific care needs. The DON stated a potential negative outcome for failure to update the care plan to include Wander Guard placement, was a direct care staff may not know a resident was supposed to have it on. During a follow-up interview on 04/14/26 at 5:06 PM, the ADM stated she was not aware Resident #1's care plan had not been updated to include the use of the Wander Guard signaling device. She stated the MDS coordinator usually updated the care plan, according to orders and information shared during morning stand-up meetings. She stated the DON was responsible for assuring the care plan was updated and for giving information to the MDS coordinator for a verbal order that would require an updated plan of care. The ADM stated the care plan was used by all staff to know how to care for a resident. She stated a potential negative outcome for failure to update the care plan to include Wander Guard placement, was staff may not be aware to check for placement of the device. Record review of the facility-provided policy titled Signaling Device, dated 04/2020, revealed: Policy.The community must ensure the resident's safety while utilizing the least restrictive means available.A plan of care will be developed and implemented with specific approaches and goals for the wanderer. Record review of the facility-provided policy titled Comprehensive Care Plan, revised 4/25/2021, revealed: PolicyEvery resident will have an individualized interdisciplinary plan of care in place. ProcedureThe Interdisciplinary Team will review the healthcare practitioner's notes and orders.and implement a Comprehensive Care Plan to meet the residents' immediate care needs including but not limited to. b. Physician orders.I. Psychosocial Mood State/Adjustment to Placement/PASRR needs as indicated .		