

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 07/28/2026
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 3 (Resident #44, Resident #1 and Resident #22) of 4 residents reviewed for infection control. CNA C failed to sanitize hands between glove changes during incontinent care on 07/27/26 for Resident #44. LVN A failed to wear proper PPE (a gown) when providing wound care on 07/27/26 for Resident #1 who was on EBP and while assisting LVN B with wound care on 07/27/26 for Resident #22 who was on EBP. LVN B failed to wear proper PPE (a gown) when assisting LVN A with wound care on 07/27/26 for Resident #1 who was on EBP. These failures could place residents at risk for the spread of infection and cross contamination. Resident #44 Record review of Resident #44's admission Record dated 07/30/26, reflected a [AGE] year-old female with an original admission date of 11/05/24. Resident #44 had diagnoses which included: cerebral infarction (stroke), muscle wasting (loss of muscle mass), depression, seizures and hypertension (high blood pressure). Record review of Resident #44's Quarterly MDS assessment dated [DATE] reflected a BIMS score of 15, indicating the resident was cognitively intact. Section GG - Functional Abilities reflected the resident required substantial/maximal assistance with toileting hygiene. Section H - Bowel and Bladder reflected the resident was occasionally incontinent of bladder and bowel. Record review of Resident #44's Comprehensive Care Plan, revised 04/01/26, reflected Resident #44 was frequently incontinent of bowel and bladder. Interventions included: Monitor for incontinence Q2H/PRN, change promptly and apply protective skin barrier. During an observation on 07/27/26 at 9:52 AM of incontinent care for Resident #44, CNA C removed the soiled brief and provided incontinent care. CNA C changed gloves and placed a clean brief on the resident. CNA C failed to sanitize hands between the glove changes. Resident #1 Record review of Resident #1's admission Record dated 07/30/26, reflected a [AGE] year-old female with an original admission date of 03/20/26. Resident #1 had diagnoses which included: cerebral infarction (stroke), acquired absence of right leg above knee (amputation of right leg above the knee), hypertension (high blood pressure), and generalized muscle weakness. Record review of Resident #1's Quarterly MDS assessment dated [DATE], reflected a BIMS score of 07, indicating the resident was severely cognitively impaired. Section M - Skin Conditions reflected the resident had one unstageable pressure ulcer (an injury to tissue caused by pressure where depth of the injury cannot be determined). Record review of Resident #1's Comprehensive Care Plan, revised 05/14/26, reflected the resident was on EBP with an intervention for staff to maintain EBP while performing wound care. Further review of the care plan, revised on 07/24/26, reflected the resident had a pressure injury (damage to the skin and underlying soft tissues caused by pressure) to the sacrum (area at the base of the spine), with an intervention for daily wound care and application of 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wound dressing. Record review of Resident #1's current Physician's Orders, dated 07/28/26, reflected the resident had an order for daily wound care and application of a wound dressing to the coccyx (tailbone), with a start date of 07/17/26. Further review reflected Resident #1 had an order for Enhanced Barrier Precautions with a start date of 04/16/26. During an observation of wound care on 07/27/26 at 10:15 AM, LVN A performed wound care to Resident #1's coccyx wound, according to Physician's Orders. LVN A put on gloves but failed to put on a gown prior to performing wound care for Resident #1. LVN B assisted LVN A to turn the resident and remove and replace linens during wound care. LVN B put on gloves but failed to put on a gown prior to assisting LVN A during wound care for Resident #1. Enhanced Barrier Precaution signage was noted at the top of Resident #1's bed and a PPE cart was noted outside Resident #1's room. Resident #22 Record review of Resident #22's admission Record, dated 07/30/26, reflected a [AGE] year-old female with an original admission date of 12/04/23. Resident #22 had diagnoses which included: congestive heart failure (a chronic condition where the heart muscle cannot pump blood efficiently), chronic obstructive pulmonary disease (a long-term lung condition that blocks airflow and makes it hard to breathe), dementia (a decline in mental ability which interferes with daily life), and muscle wasting. Record review of Resident #22's Quarterly MDS assessment, dated 05/29/26, reflected a BIMS score of 00, indicating the resident was severely cognitively impaired. Record review of Resident #22's Comprehensive Care Plan, revised 07/27/26, reflected the resident was on EBP with an intervention for staff to maintain EBP while performing wound care. Further review of the care plan, revised on 07/24/26, reflected the resident had a Kennedy ulcer (a rapidly developing skin wound that often appears during the final weeks of life) with an intervention for daily wound care and application of a wound dressing. Record review of Resident #22's current Physician's Orders, dated 07/28/26, reflected the resident had an order for daily wound care and application of a wound dressing to the sacrum with a start date of 07/20/26. Further review reflected Resident #22 had an order for Enhanced Barrier Precautions with a start date of 07/27/26. During an observation of wound care on 07/27/26 at 10:40 AM, LVN B put on gloves and a gown and performed wound care to Resident #22's sacral wound, according to Physician's Orders. LVN A assisted LVN B to turn the resident and remove and replace pillows and linens during wound care. LVN A put on gloves but failed to put on a gown prior to assisting LVN B during wound care. Enhanced Barrier Precaution signage was noted at the top of Resident #22's bed and a PPE cart was noted outside Resident #22's room. During an interview on 07/27/26 at 10:56 AM, LVN A stated she failed to wear a gown while providing wound care for Resident #1. LVN A stated a gown, and gloves should always be worn while providing wound care and stated she did not think about putting a gown on until she had already started the wound care procedure. She stated she was trained on EBP through computer-based training and in-service training at the facility. LVN A stated the purpose of EBP was to protect staff and residents from cross-contamination of germs. She stated she should have also worn a gown while assisting LVN B with Resident #22's wound care due to assisting with a high-contact activity, such as removing and replacing linens and pillows. LVN A stated a potential negative outcome for failure to wear a gown during wound care for a resident on EBP was cross-contamination. During an interview on 07/27/26 at 11:00 AM, LVN B stated she failed to wear a gown while assisting LVN A during wound care for Resident #1. She stated she should have worn a gown for high-contact activity, such as turning the resident and handling the bed linens, due to the resident being on EBP. She stated she was trained on EBP upon hire and also through computer-based training during the past month. LVN B stated the purpose of EBP was to protect the residents from the spread of germs. She stated a gown should be worn for activities such as changing linens, transferring, dressing, and when the resident had an indwelling device such as a catheter. LVN (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B stated a potential negative outcome for failure to wear a gown during wound care for a resident on EBP was the spread of germs. During an interview on 07/27/26 at 3:25 PM, CNA C stated she did not sanitize her hands in between glove changes during incontinent care for Resident #44. She stated she was focused on the task she was doing and forgot to use hand sanitizer when she changed her gloves. CNA C stated she usually carried a bottle of hand sanitizer in her pocket, but she was assigned to do showers, so she did not have it with her. She stated she was trained on proper hand sanitizing through in-services and computer-based training. CNA C stated hands should be sanitized before beginning incontinent care, between glove changes, and when care was completed. CNA C stated a potential negative outcome for failure to properly sanitize hands was infection. During an interview on 07/28/26 at 10:18 AM, the ADM stated she was not aware staff were not properly sanitizing hands between glove changes and were not wearing a gown while performing and assisting with wound care for residents on EBP. She stated nursing administration was responsible for ensuring hand sanitizing and EBP protocol were followed. The ADM stated all staff were trained on hand hygiene and EBP and staff were monitored through nursing administration rounds, skills checks, and regular in-services. She stated her expectation of staff was that proper PPE was used for EBP residents and hand hygiene was performed per policy. The ADM stated a potential negative outcome for failure to utilize proper PPE and perform hand hygiene was infection. During an interview on 07/28/26 at 10:37 AM, the DON stated she was not aware staff were not properly sanitizing hands between glove changes and were not wearing a gown while performing and assisting with wound care for residents on EBP. She stated nursing administration was responsible for ensuring protocol was followed for EBP and hand hygiene. She stated the purpose of EBP was to prevent the spread of infection. She stated a gown should be worn during wound care and should also be worn by anyone assisting with wound care. The DON stated hand hygiene should be performed before and after contact with a resident and between each glove change. She stated all staff were trained on EBP and hand hygiene through in-services and were monitored through skills checks conducted by nursing administration. The DON stated a potential negative outcome for failure to perform proper hand hygiene and wear proper PPE during care of a resident on EBP was infection. Record review of the facility's policy titled Hand Hygiene, revised 10/24/2022 reflected: PolicyHand hygiene is used to prevent the spread of pathogens in healthcare settings. Hand hygiene is a general term that describes hand washing using soap and water or the use of an alcohol-based hand rub (ABHR) to destroy harmful pathogens, such as bacteria or viruses, on the hands. 1. You should always perform hand hygiene: -Before applying and after removing personal protective equipment (e.g. gloves, gown, mask, face shield/goggles) . Record review of the facility's policy titled Enhanced Barrier Precautions, dated 10/24/2022 reflected: PolicyEnhanced Barrier Precautions (EBP) are a CDC guidance to reduce the transmission of multi-drug resistant organisms (MDRO) in health care settings, including nursing homes. EBP require team members to wear a gown and gloves while performing high-contact care activities with residents who are infected or colonized with a targeted MDRO, or who have open wound or indwelling medical device. Procedure .2. Determine if a resident has any wounds . Examples of chronic wounds include, but are not limited to, pressure ulcers.4. High contact resident care activities: Wound care: any skin opening requiring a dressing. Record review of the facility's undated sign posted above the bed of Resident #1 and Resident #22, titled, Enhanced Barrier Precautions, reflected: PROVIDERS AND STAFF MUST ALSO: Wear gloves and a gown for the following High-Contact Resident Care Activities.Wound Care; any skin opening requiring a dressing		

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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** Based on observations, interviews, and record review, the facility failed to ensure that each resident received adequate supervision and assistance devices to prevent accidents for 1 of 2 residents (Resident # 51). The facility failed to ensure Resident #51 wore a smoking apron as indicated in his physician orders during the smoke break on 07/27/26 at 11AM. This failure could place residents at risk for inadequate protection from potential injury. Findings included: Record review of Resident #51's undated face sheet revealed a [AGE] year-old male admitted on [DATE]. Resident #51 had the following diagnoses: anxiety (mental health condition), hypertensive retinopathy, bilateral (damage to the blood vessels in the eye caused by high blood pressure), vascular dementia, unspecified severity, with other behavioral disturbance (decline in thinking skills caused by conditions like strokes that block or reduce blood flow and oxygen to the brain), intermittent explosive disorder (mental health condition defined by sudden, repeated bursts of extreme anger), weakness, muscle wasting and atrophy, not elsewhere classified, multiple sites (thinning, shrinking, and loss of muscle mass, and strength), and lack of coordination. Record review of Resident #51's clinical record revealed his comprehensive MDS assessment, completed 1/9/26, listed him with a BIMS score of 7, which indicated severe cognitive impairment. The MDS indicated Resident #51 used tobacco at the time of the assessment. Record review of Resident #51's physician active orders, dated 7/27/26, revealed an order dated 6/18/26 that a smoking apron was to be used on all smoke breaks. Record review of Resident #51's Care Plan Report, dated 10/14/19, revealed Resident #51 smoked and tobacco abuse. The goal was Resident #51 would remain free from smoking related injuries through the next evaluation. Interventions initiated on 5/1/26 were that Resident #51 would keep all lighters/matches with facility staff for safety, Resident #51 would participate in supervised smoke breaks, Resident #51 would wear a smoking apron while smoking for protection, and a smoking evaluation would be completed upon admission by a licensed nurse. Record review of Resident #51's Safe Smoking Assessment, dated 7/12/26, revealed Resident #51 could independently light smoking materials safely, Resident #51 could dispose of ashes or other tobacco-related residue appropriately, Resident #51 required direct supervision while smoking, all smoking materials would be kept at the nurse's station, and the care plan was up to date or updated. During an observation on 7/27/26 at 11:00 a.m., Resident #51 was observed outside smoking with other residents. HK D and HK E passed out smoking materials, lit cigarettes, and supervised residents during the smoke break. Resident #51 was observed smoking a lit cigarette independently. Resident #51 was not wearing a smoking apron. There were no cigarette ash or burns observed on his clothing. During an interview on 7/28/26 at 9:37 a.m., HK D stated she passed smoking materials and supervised residents during the 11:00 AM smoke break on 7/27/26. HK D stated she was aware that Resident #51 and another resident wore smoking aprons. HK D stated Resident #51 sometimes refused to wear the smoking apron. HK D stated Resident #51 was supposed to wear the apron. HK D stated she would still allow Resident #51 to smoke when he refused to wear the smoking apron. HK D stated she did not know why she allowed this. HK D stated she did not know why Resident #51 was supposed to wear the smoking apron. HK D stated she did not remember if Resident #51 wore a smoking apron yesterday during the 11:00 AM smoke break. HK D stated she was trained in the smoking policy and smoking supervision requirements. HK D stated a potential negative outcome was that Resident #51 could get burned. During an interview on 7/28/26 at 10:00 a.m., HK E stated she passed smoking materials, smoking (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	apron, and supervised residents during the 11:00 AM smoke break on 7/27/26. HK E stated she was not aware Resident #51 was required to wear a smoking apron while smoking. HK E stated she was not supposed to allow residents who were required to wear smoking aprons to smoke if they refused to wear them. HK E stated she would notify the charge nurse if a resident refused to wear a smoking apron and then allow them to address the situation. HK E stated she was only given one smoking apron by another staff member as they prepared to go outside to smoke so she gave it to another resident whom she knew wore the smoking apron. HK E stated she had never seen Resident #51 wear a smoking apron during smoke breaks. HK E stated Resident #51 smoked a cigarette without a smoking apron on 7/27/26 during the 11:00 AM smoke break. HK E stated they were notified of residents who were required to wear smoking aprons during morning meetings and by other staff as she did not have access to the resident's electronic health records. HK E stated the smoking aprons were to prevent residents from burning themselves or their clothing. HK E stated she was trained in the smoking policy and how to supervise residents during smoke breaks at the town hall meetings held on the second Tuesday of every month. HK E stated a potential negative outcome was that residents could catch on fire or get burned. During an interview and observation on 7/28/26 at 11:30 AM, Resident #51 stated he smoked cigarettes. Resident #51 stated he did not wear a smoking apron while smoking. Resident #51 stated he was willing to wear a smoking apron and stated he had not refused to wear a smoking apron. Observation reflected there were no burns or burn marks observed on Resident #51's clothing. A full interview was unable to be obtained due to the resident's level of cognitive functioning. During an interview on 7/28/26 at 11:50 AM, the ADM stated the smoking policy was that all residents who smoked were required to be supervised by staff, smoking assessments were completed upon admission and then quarterly thereafter. The ADM stated smoking aprons were provided to residents that were at risk of burning themselves. The ADM stated there were seven scheduled smoke breaks each day. The ADM stated she was not aware Resident #51 had physician orders that required him to wear a smoking apron and was not wearing it. The ADM stated all staff that supervised smoke breaks had received training on the requirements, how to properly monitor residents, and how to know who was supposed to wear a smoking apron. The ADM stated there was also a list of residents who were required to wear smoking aprons located inside the box that stored the smoking materials. The ADM stated the person supervising the residents, herself, and the DON were responsible for ensuring residents wore smoking aprons. The ADM stated she expected staff to follow physician orders or the staff member could hold the cigarette for the residents if they chose to allow the resident to smoke without the apron. She stated a potential negative outcome was that residents could get burned. During observation and interview on 7/28/26 at 12:04 PM the DON stated during the smoke breaks, staff passed the smoking materials to residents, lit the cigarettes, and gave smoking aprons to residents required to wear them. The DON stated she was not aware there was a resident that was not wearing a smoking apron that was required to. The DON stated she just learned today that Resident #51 was supposed to wear a smoking apron when she was outside this morning and observed him wearing an apron. The DON stated she asked the staff member who supervised the smoke break after she observed Resident #51 wearing a smoking apron and who told her there was a recent change a couple of weeks ago and that he was required to wear the apron because he was observed with ashes on his clothing after smoking. The DON stated she was on leave during that time and was not made aware of the orders when she returned to work. The DON stated she was not aware if Resident #51's name was added to the list of residents who were required to wear smoking aprons that were located inside the box that stored the smoking materials. The DON stated the list in the smoking materials box was how staff were notified of residents that were required to wear (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	smoking aprons. The DON stated staff had been trained on smoking supervision responsibilities, but she was not sure when they were last trained. The DON stated she and the ADON were responsible to ensure residents were wearing aprons as required. The DON stated she needed to identify which staff member added the orders into the resident's electronic medical record since they did not update her on the changes. The DON stated she expected staff to ensure residents wore smoking aprons that were on the list and to notify her if someone was not smoking safely and of any changes regarding the resident's ability to smoke. The DON stated she expected staff to follow physician orders. The DON stated a potential negative outcome was that residents could get burned. Resident #51's name was observed on the list of residents required to wear smoking aprons that were inside the smoking materials container. In an email on 8/03/26 at 11:57 AM, the ADM stated they did not have specific policies on following physician orders. Record review of facility provided policy titled, Smoking revised October 12, 2022, revealed in part: It is the policy of this community to accommodate residents who desire to smoke, including electronic cigarettes by taking reasonable precautions, providing a safe environment for them, and protecting the non-smoking residents. PROCEDURE 6. A Licensed Nurse will complete a Resident Smoking Assessment to assess residents who express a desire to smoke, including electronic cigarettes, upon admission, quarterly, annually and upon significant change of condition identification, and present it to the Interdisciplinary Team (IDT) for review. 8. IDT will develop an individualized plan for safe storage, use of smoking materials, assistance and required supervision for residents who smoke. This is documented on the Resident Smoking Assessment, the resident's Plan of Care, and discussed with the resident and Responsible Party at resident care conference meetings. 9. Resident will be informed of smoking violations and after three (3) infractions may be discharged from the facility as an unsafe smoker.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents who needed respiratory care were provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan and the residents' goals and preferences for 1 (Resident #58) of 6 residents reviewed for respiratory care. The facility failed to ensure that Resident #58's oxygen tubing was stored properly while not in use when it was observed on the floor during an initial tour observation on 07/26/26 and on an observation on 07/27/26. This failure could place residents at risk for respiratory compromise and infection. Record review of Resident #58's admission Record dated 07/28/26 reflected a [AGE] year-old female with an original admission date of 07/22/17. Resident #58 had diagnoses which included: cerebral infarction (stroke), chronic respiratory failure (a condition where the respiratory system fails to properly exchange oxygen), and cognitive communication deficit (trouble with communication caused by problems with thinking skills). Record review of Resident #58's Quarterly MDS assessment dated [DATE], reflected a BIMS score of 00, indicating the resident was severely cognitively impaired. Section O - Special Treatments, Procedures and Programs revealed Resident #58 used oxygen therapy while a resident. Record review of Resident #58's Comprehensive Care Plan, revised 03/18/26, reflected Resident #58 had dyspnea (shortness of breath and chest tightness) and chest pain related to cardiac insufficiency (heart failure). Interventions included: Apply O2 for c/o chest pain as ordered. Record review of Resident #58's current Physician Orders dated 07/28/26, reflected the following order with a start date of 07/12/26: May use O2 @ 2L-4L to maintain O2 sat 90 and above. Record review of Nursing Progress Notes, dated 07/13/26 at 1:42 PM, reflected the following: Resident resting quietly in bed. Respirations nonlabored and even. Incontinent b/b with care provided every 2 hours. Resident had a low O2 sat of 87% @ RA at beginning of shift with hospice notified. [Name] RN states they will have an oxygen concentrator delivered tomorrow. Oxygen tank used with O2 at 2lpm via nasal cannula. O2 sat up to 92% with oxygen in place later rechecked resident with O2 sat at 97% @ RA. Resident not wanting to use oxygen. No complaints of SOB. Call light at reach. During an observation and attempted interview on 07/26/26 at 11:26 AM, Resident #58's oxygen tubing and nasal cannula (tube that inserts into nostrils to deliver oxygen) were observed on the floor near the resident's bed. Resident #58 was observed in bed and did not respond to surveyor questions. During an observation and attempted interview on 07/27/26 at 9:33 AM, Resident #58's oxygen tubing and nasal cannula were observed on the floor near the resident's bed. Resident #58 was observed in bed and did not respond to surveyor questions. During an interview on 07/28/26 at 10:18 AM, the ADM stated she was not aware that oxygen tubing was not being properly stored while not in use by the resident. She stated oxygen tubing should be stored in a labeled bag and should not be on the floor. She stated all nursing staff as well nursing administration, and the ADM were responsible for ensuring oxygen tubing was properly stored. The ADM stated all staff had been trained on proper oxygen tubing storage through in-services and computer-based training modules. She stated her expectation of staff was that all oxygen tubing was stored properly in a plastic bag and kept off the floor. The ADM stated a potential negative outcome for failure to properly store oxygen tubing was increased risk of infection to residents. During an interview on 07/28/26 at 10:37 AM, the DON stated she was not aware that oxygen tubing was not being properly stored while not in use by the resident. She stated oxygen tubing should not be on the floor and should be stored in a bag when not in use. The DON stated all nursing staff had been trained on proper oxygen storage through respiratory training conducted twice per year through (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were stored in locked compartments for 2 of 5 medication carts (Overstock Medication Cart and Treatment Cart) observed for storage. The facility failed to ensure the Overstock Medication Cart and Treatment Cart were secured when unattended on 7/26/26. This failure could place residents at risk of having access to unauthorized medications and/or lead to possible harm, drug overdose, or drug diversion. Findings included: During an observation and interview on 7/26/26 at 10:06 AM, the Overstock Medication Cart and Treatment Cart were observed next to each other by the nurse's station with the locks popped out and without staff present. Residents, staff, and visitors were observed in and around the area since the nurse's station was in the center of the building in a high traffic area. LVN B was observed sitting at the nurse's station working on a computer and she was not faced towards the Overstock Medication Cart and Treatment Carts. Additionally, the nurse's station counter was higher than LVN B's eyes and obstructed her view from the Overstock Medication Cart and Treatment Carts. LVN F came from around the corner from hall 4 and approached the Overstock Medication Cart and Treatment Carts. All the drawers of the Overstock Medication Cart were opened and various blister packs of pills and bottles of medications and medical supplies were observed in the drawers of the Overstock Medication Cart that opened. The drawer that contained the narcotic medications opened however the lock box was secure. All the drawers of the Treatment Cart were opened and various creams, ointments, and gels that were used to treat skin issues were observed in the drawers of the Treatment Cart that opened. Additionally, there were bottles of iodine, gloves, bandages, and gauze. The drawer that contained the internal lock box was locked. LVN F stated she was responsible for the Overstock Medication Cart but not the Treatment Cart. LVN F stated she did not have the key to the Treatment cart and did not know who left it unlocked but only the nurses had keys to that cart. LVN F stated she was covering and she passed out medications and was in the process of transferring medications from the Overstock Medication Cart to the Medication Aide cart that had run out. LVN F stated the medications kept in the Overstock Medication Cart were medications currently prescribed to residents that did not fit in the Medication Aide Cart. LVN F stated all carts that contained medications in them must be always locked while unattended. LVN F stated she was unaware that she left the Overstock Medication Cart unlocked. LVN F stated the system to ensure medication carts were locked at all times was to ensure they locked them when they were left unattended. LVN F stated she was trained on Medication Carts, Medication Pass, and Medication Storage but she was not sure when she was last trained. LVN F stated she was responsible for ensuring the Overstock Medication Cart was locked before she walked away from it. LVN F stated a potential negative outcome was that residents and visitors could open it and take medications. During an interview on 7/26/26 at 10:28 AM, LVN B stated she was one of the charge nurse's during the shift. LVN B stated neither of the carts were assigned to anyone in particular but only the nurse's had a key to the Treatment cart, and the Overstock Medication Cart was for storage of resident's medications. LVN B stated LVN F accessed the Overstock Medication Cart and left it unlocked and it was LVN F's responsibility to ensure she locked it before she left it unattended. LVN B stated she did not know who left the Treatment Cart unlocked. LVN B stated both the Treatment cart and the Overstock Medication Cart must be locked while unattended. LVN B stated she was not aware both carts were unlocked and unattended. LVN B stated they monitored medication carts and (continued on next page)		

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 07/28/2026
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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	checked them routinely to ensure they were locked. LVN B stated she was trained on medication carts, medication storage, and medication pass but could not remember the last time she was trained. She stated she expected staff to ensure all medication carts were locked, medications were dated, labeled, and that the keys were not left where someone could grab them. LVN stated a potential negative outcome was that residents and staff could access the medications in the cart and grab the wrong pills or get ahold of narcotics. During an interview on 7/28/26 at 11:50 AM, the ADM stated the policy was that medication carts and treatment carts should be locked anytime they were unattended and anytime a staff was not actively in the cart. The DON stated she was not aware staff left treatment and medication carts unlocked and unattended. She stated the nurses were responsible for ensuring the treatment cart was locked when unattended. The ADM stated the DON, and the ADM were responsible for ensuring medication carts were locked when unattended. The ADM stated they currently did not have a designated treatment nurse but both nurses working on the shift had access to the treatment cart. The ADM stated staff were trained on medication pass, medication storage, and medication carts upon being hired, quarterly, and by being in-serviced periodically. The ADM stated the DON, the ADON, and herself also checked medication carts daily during rounds. The ADM stated she expected staff to lock the carts before they walked away from them. The ADM stated a potential negative outcome was that medications could have been stolen or ingested by residents, visitors, and staff members. During an interview on 7/28/26 at 12:04 PM, the DON stated that the policy was that medication carts should be locked at all times when staff were not standing with them. The DON stated she was made aware afterwards that staff left the medication and treatment carts unlocked and unattended. The DON stated the ADM, ADON, and herself did rounds throughout the day and checked the carts and would address any concerns with staff at that time. The DON stated the treatment cart was also supposed to be locked because there were items stored in there that were supposed to be kept away from children. The DON stated staff were trained and in-serviced on medication carts, storage, and medication pass. She stated she expected staff to lock the carts when they walked away from them. The DON stated a potential negative outcome was that residents or staff could have stolen and/or ingested the medications. Record review of the facility provided policy, Security of Medication Cart, revised April 2007, revealed in part: Policy Heading: The medication cart shall be secured during medication passes. 1. The nurse must secure the medication cart during the medication pass to prevent unauthorized entry.4. Medication carts must be securely locked at all times when out of the nurse's view.5. When the medication cart is not being used, it must be locked and parked at the nurses' station or inside the medication room.		

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NAME OF PROVIDER OR SUPPLIER Focused Care at Lamesa		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 N 15th St Lamesa, TX 79331	
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 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 in 1 of 1 kitchen (Kitchen A) reviewed for food storage. On 07/26/2026 facility failed to properly label food stored in the refrigerator. This failure could place residents at risk for foodborne illness. Findings included: The following observation was made on 07/26/2026 at 09:55 a.m. during the initial tour of the kitchen: Bowl of white pudding with no label. Bowl of red sauce with no label. During an interview on 07/26/2026 at 02:35 p.m., the DS stated the bowl of white pudding was yogurt, and the red sauce was cranberry sauce. He stated the bowls were not labelled when placed in the refrigerator. He stated all items should be labelled when placed in the refrigerator. During an interview on 07/27/2026 at 03:30 p.m., the DS stated all food in the refrigerator should be labelled and dated. He stated all dietary staff were trained in proper food storage. He stated he was not aware the bowl was not labelled. He stated he checked refrigerators 3 times a week on Monday, Wednesday and Friday. He stated his Assistant Manager checked them on Tuesday and Thursday. He stated the purpose for labelling and dating food was food safety. He stated the potential negative outcome could be food borne illness. During an interview on 07/27/2026 at 03:55 p.m., the ADM stated all food in the refrigerator should be labelled and dated. She stated the purpose of labeling the food was to know when it was opened and when it would expire. She stated all staff were trained in proper food storage. She stated she was not aware food was being stored without a label. She stated the DS and ADM were responsible for making sure food was properly stored. She stated the DS checked the refrigerators weekly and the dietitian checked them monthly. She stated the potential negative outcome could be food borne illness. Record review of the facility's policy titled Food Labeling and Dating, revised 1/2018 reflected: Food should be stored in a safe and sanitary method to prevent contamination and food-borne illness. All food should be stored according to local, state and federal regulations. 2. Refrigerators. c. Refrigerated food should be dated, labeled and sealed.		