STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675329	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Levelland Nursing & Rehabilitation Center	210 West Ave Levelland, TX 79336

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 7 residents (Resident #1) reviewed for accidents and supervision. The facility failed to ensure adequate supervision of Resident #1 who was newly admitted to the facility on [DATE] around 2:00 PM and exhibiting signs of confusion. Resident #1 then eloped from the facility approximately 4 (four) hours later between 6:15 PM and 6:35 PM and was picked up by a Community Member and transported to the local police department. Staff were unaware of Resident #1's elopement when the facility was notified by the police department via telephone on 08/04/25 at approximately 6:50 PM that the resident had been brought to the police station. The noncompliance was identified as PNC. The IJ began on 08/04/25 and ended on 08/08/25. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk of harm, serious injury or death.Record review of Resident #1's face sheet, dated 08/14/25 revealed Resident #1 was admitted to the facility on [DATE] with the following diagnoses: dementia (progressive decline in cognitive functions), cerebral infarction (death of brain tissue due to lack of blood supply), chronic kidney disease, major depressive disorder (persistent feelings of sadness and loss of interest that can significantly impact daily life), hypertension (high blood pressure), and atrial fibrillation (irregular heart rhythm). Record review of the Nursing admission Assessment, authored by LVN B on 08/04/25 at 5:15 PM, revealed Resident #1 was alert and disoriented. Resident #1 was confused due to dementia and exhibited both short-term and long-term memory problems. Nursing admission Assessment further revealed Resident #1 was independently ambulatory, had no mobility limitation, and had no verbal expressions to leave facility. Record review of the Wandering Risk Scale, initiated on 08/04/25 at 2:59 PM and completed on 08/05/25, and also completed 72 hours after admission on [DATE], revealed:Resident #1's admission Wandering Risk score was 18, indicating the resident was above high risk to wander.Resident #1's 72-hour Wandering Risk score was 18, indicating the resident was above high risk to wander. Record review of the Elopement note, authored by LVN B on 08/04/25 at 6:50 PM, revealed: Incident Description: Resident was found wandering down the street from the facility. The resident was picked up by a concerned citizen and taken to the police department. The police department called the facility and informed LVN B of the location of the resident. Police brought the resident back to the facility. The resident was confused and unable to recall the event. The resident was assessed for injury and no injuries were noted. Resident was placed on one-to-one monitoring and notifications were made to ADM, DON, Physician and family. Record review of Resident #1's Baseline Care Plan, dated 08/04/25, revealed the resident was alert and cognitively impaired and used a walker as an assistive device. The Baseline Care Plan further revealed Resident #1 was not an elopement risk. Record review of Resident #1's BIMS score, dated 08/05/25, revealed a score of 0, which indicated the resident's cognition was severely impaired. Record review of the facility's Form 3613-A (Provider Investigation Report), dated 8/05/25, revealed the ADM was notified by LVN B on 08/04/25 at 7:12 PM, of Resident #1's elopement from the facility. Resident #1 had been picked up by a citizen and taken to the police station then escorted back to the facility by police. The resident was assessed and found to have no injuries and did not require medical treatment. A police report was not filed. Resident #1 was placed on one-to-one supervision upon return to the facility and a wander guard device was placed on Resident #1 on 08/06/25. Door alarms were checked and found to be functioning properly. Staff in-services were initiated for ANE, elopement, door alarms, and monitoring of newly admitted residents. Record review of Resident #1's Discharge MDS, dated [DATE], revealed:Section C - Cognitive Patterns - BIMS revealed a score of 0, which indicated the resident's cognition was severely impaired.Section GG - Functional Abilities revealed resident was able to stand from a sitting position and walk 150 feet independently. Record review of Discharge summary, dated [DATE], revealed Resident #1 was discharged to an alternate long term care facility with belongings on 08/08/25. During an interview on 08/13/25 at 1:30 PM, the ADM stated Resident #1 was admitted to the facility on [DATE] around 2:00 PM and eloped approximately 4 (four) hours later. She stated the resident was picked up approximately 400 meters from the facility by a citizen of the community in a private vehicle and was taken to the local police station. The facility was contacted by the police department and an officer escorted Resident #1 back into the facility. The ADM stated Resident #1 was assessed upon return to the facility and was found to have no injuries and had no recollection of leaving the facility. The ADM stated she was made