

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675329	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Levelland Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 of 4 residents (Resident #1, Resident #17 and Resident #43) reviewed for infection control. -CNA B did not perform hand hygiene between all glove changes when providing incontinence care and catheter care to Resident #1.- CNA D did not perform hand hygiene between all glove changes when providing incontinence care to Resident #17.- CNA E did not perform hand hygiene between all glove changes when providing incontinence care to Resident #43. These failures could place residents at risk for cross contamination and infection. The findings include: Resident #1 Record review of the admission record for Resident #1, dated 01/14/26 revealed a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: encounter for surgical aftercare following surgery on the digestive system, neuromuscular dysfunction of bladder (loss of bladder control caused by nerve damage), and urinary tract infection. Record review of the quarterly MDS assessment for Resident #1, dated 10/20/25 revealed Resident #1 was dependent for toileting hygiene - the helper does all of the effort and the resident does none of the effort to complete the activity, or the assistance of 2 or more helpers was required for the resident to complete the activity. The MDS further revealed Resident #1 had an indwelling catheter. Record review of the current care plan for Resident #1, undated, revealed there was a focus area: Neurogenic Bladder: [Resident #1] has indwelling catheter related to Neurogenic Bladder. With a revised date of 10/23/25. During an observation on 01/15/26 at 9:20 AM, CNA B provided incontinence care and catheter care for Resident #1 with the help of CNA C. CNA B washed her hands with soap and water and then put on a clean gown and gloves. CNA B then unfastened the brief for Resident #1 and turned him on his side with the help of CNA C. CNA B then removed the old brief and removed her gloves. CNA B then stated, Wash my hands and put on clean gloves without performing hand hygiene. CNA B then placed a clean sheet under Resident #1 and Resident #1 was turned on his back again. CNA B then cleansed the groin area and catheter with wipes. CNA B then removed her gloves. CNA then stated, Wash my hands and put on clean gloves without performing hand hygiene. CNA B then put a clean brief on Resident #1, secured the brief and removed the sheet that was placed under Resident #1. CNA B then removed her gloves, and gown washed her hands with soap and water. During an interview on 01/15/26 at 10:08 AM, CNA B stated she had been trained on hand hygiene between all glove changes, but it had been a while, and she could not remember the last time she was trained. CNA B stated she was not sure if she had to actually wash her hands in front of the state surveyor and that was why she said out loud every time she should have washed her hands. CNA B stated the ADON did the infection control training at the facility. CNA B stated a potential negative outcome to the residents was they could get an infection. Resident #17 Record review of the admission record for Resident #17, dated 01/16/26 revealed a [AGE] year-old female who was admitted to the facility on [DATE] with the following diagnoses: displaced Tri malleolar fracture of right lower leg (broken right leg), type 2 diabetes mellitus (blood sugar problems) and unspecified dementia (loss of ability to think, remember and (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	noted. Record review of the facility training document titled, Peri-Care, undated, revealed: Performance Criteria: .4. Washes hands, applies disposable gloves and other PPE as indicated. and 19. Discard soiled gloves, wash hands and don clean gloves. Were checked off as Met for CNA B. Record review of the facility training document titled, Peri-Care, dated 12/12/25, revealed: Performance Criteria: .4. Washes hands, applies disposable gloves and other PPE as indicated. and 19. Discard soiled gloves, wash hands and don clean gloves. Were checked off as Met for CNA D. Record review of the facility policy titled, Handwashing/Hand Hygiene, with a revised date of 08/2019 reflected the following: Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation:2. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors.7. Use an alcohol based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:.h. before moving from a contaminated body site to a clean body side during resident care.m. after removing gloves.9. The use of gloves does not replace hand washing/ hand hygiene.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation interview and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public for 4 of 6 shared bathrooms (rooms [ROOM NUMBERS] shared bathroom, rooms [ROOM NUMBERS] shared bathroom, rooms [ROOM NUMBERS] shared bathroom and rooms [ROOM NUMBERS] shared bathroom); in that: The facility failed to ensure the hot water in the shared bathroom sinks in rooms [ROOM NUMBERS], rooms [ROOM NUMBERS], rooms [ROOM NUMBERS] and rooms [ROOM NUMBERS] were at a safe and comfortable temperature. This failure could place residents at risk for injuries to include scalding and burns. The findings include: During an observation on 01/15/26 at 11:49 AM, the hot water at the hand sink in the shared bathroom for rooms [ROOM NUMBERS] was checked with a water thermometer and noted to be 122 degrees Fahrenheit. During an observation on 01/15/26 at 11:52 AM, the hot water at the hand sink in the shared bathroom for rooms [ROOM NUMBERS] was checked with a water thermometer and noted to be 124.6 degrees Fahrenheit. During an observation on 01/15/26 at 11:54 AM, the hot water at the hand sink in the shared bathroom for rooms [ROOM NUMBERS] was checked with a water thermometer and noted to be 125.6 degrees Fahrenheit. During an observation on 01/15/26 at 11:56 AM, the hot water at the hand sink in the shared bathroom for rooms [ROOM NUMBERS] was checked with a water thermometer and noted to be 117.5 degrees Fahrenheit. During an interview on 01/15/26 at 12:01 PM, the MS stated the plumbers had worked on the water heater recently and it was supposed to be set. The MS stated the water temperatures in the facility were last checked two weeks ago. During an interview on 01/16/26 at 9:54 AM, the MS stated the mixing valve went out for the water heater and that was why the water temperatures were too high yesterday (01/15/26). The MS stated the water temperatures should be between 100 degrees Fahrenheit and 110 degrees Fahrenheit. The MS stated he already ordered a new part for the water heater mixing valve. The MS stated he did not know when the mixing valve went out for the water heater and stated the city has hard water that would cake up on the mixing valve and that was probably why it went out. The MS stated he was trained to check the water temperatures in random rooms weekly and stated he did not know why he had not checked the water temperatures in two weeks. The MS stated he did not keep logs of the water temperature checks and did not know he needed to. The MS stated the residents had an increased risk of being scalded or burned, needing first aid. During an interview on 01/16/26 at 10:34 AM, the ADM stated she expected the water temperatures at the hands sinks to be between 100 degrees Fahrenheit and 110 degrees Fahrenheit. The ADM stated she did not know why the water temperatures were hotter yesterday (01/15/26). The ADM stated the plumbers were at the facility not too long ago due to the water being too cold. The ADM stated the plumber made some repairs and she thought everything had been fixed. The ADM stated it had not been too long since the water temperatures were last checked at the facility. The ADM stated a potential negative outcome to the residents was getting a burn. Record review of the facility's policy titled, Water Temperatures, Safety of with a revised date of 12/2009, reflected the following: Policy Statement: Tap water in the facility shall be kept within a temperature range to prevent scalding of residents. Policy Interpretation and Implementation: 1. Water heaters that service resident rooms, bathrooms, common areas, and tub/shower areas shall be set to temperatures of not more than 110 degrees Fahrenheit. or the maximum allowable temperatures per state regulation. 2. Maintenance staff is responsible for checking thermostats and temperature controls in the facility and recording these checks in a maintenance log. 3. Maintenance staff shall conduct periodic tap water temperature checks and record the water temperatures in a safety log.		

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to conduct a comprehensive assessment of a resident in accordance with the timeframes, 14 calendar days after admission, excluding readmission in which there is no significant change in the resident's physical or mental condition and not less than once every 12 months for 2 of 24 residents (Resident #8 and Resident #34) reviewed for comprehensive assessments. The facility failed to ensure Resident #8's and Resident #34's annual MDS Assessments were completed within 12 months of the previous MDS Assessments. This failure could place residents at risk of not having their medical needs met and assessments completed timely, which could result in denial of services and/or payment for services. Findings included: 1. Record review of Resident #8's electronic face sheet, dated 01/15/2026, revealed a [AGE] year-old female admitted on [DATE]. The face sheet included the following diagnoses: Unspecified open wound, right hip, subsequent encounter (admitting diagnosis); Unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (cognitive decline (memory, thinking, judgment) significant enough to interfere with daily life); and Bipolar II disorder (mental health condition that causes extreme mood swings). Record review of Resident #8's Annual MDS, dated [DATE], under Section C Cognitive Patterns, Resident #8's MDS revealed a BIMS of 11, indicating the resident was moderately cognitively impaired. Additionally, under section Z0500 Signature of RN Assessment Coordinator verifying Assessment Completion, Section A (identification information) was blank, and Section B (hearing, speech and vision) was also blank, indicating the document was not completed. Record review of Screenshot of Resident #8's annual MDS assessment information, undated, indicated the assessment was in progress with an ARD/Target date of 11/25/2025. The screenshot indicated a complete by date of 12/12/2025. 2. Record review of Resident #34's electronic face sheet, dated 01/15/2026, revealed a [AGE] year-old female admitted on [DATE]. The face sheet included the following diagnoses: Alzheimer's Disease with late onset (progressive, irreversible neurodegenerative brain disorder and the most common cause of dementia) and essential primary hypertension (elevated blood pressure). Record review of Resident #34's Annual MDS, dated [DATE], under Section C (Cognitive Patterns) Resident #34's MDS revealed a BIMS of 11, indicating the resident was moderately cognitively impaired. Additionally, under section Z0500 Signature of RN Assessment Coordinator verifying Assessment Completion, Section A (identification information) was blank, and Section B (speech, hearing and vision) was also blank, indicating the document was not completed. Record review of Screenshot of Resident #34's annual MDS assessment information, undated, indicated the assessment was in progress with an ARD/Target date of 12/7/2025. The screenshot indicated a complete by date of 12/7/2025. During an interview on 01/17/2026 at 11:00 a.m., the ADM stated the MDS nurse was responsible for completing all MDS assessments. The ADM stated the facility did not currently have an MDS nurse. The ADM stated the CN was assisting with completing MDS assessments for the facility. The ADM stated she was not aware Resident #8's and Resident #34's annual MDS assessments were not completed. The ADM stated if the RN Assessment Coordinator's signature was not completed on the annual MDS assessment, the document was not completed. The ADM stated the MDS nurse kept up with due dates for all MDS assessments, and the Corporate CN monitored for completion. The ADM stated she was responsible for ensuring they were completed as well. The ADM stated she did not receive training on MDS. The ADM stated all MDS assessments were expected to be completed by the due dates. The ADM stated if an MDS assessment was not completed timely, the resident's unique needs may not be addressed or updated for their care planning. During an interview on 01/17/2026 at 11:45 a.m., the CN stated the MDS nurse was responsible for ensuring all MDS assessments were completed. The CN stated since the facility did not have an MDS nurse, the CN was assisting with (continued on next page)		

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completing MDS assessments. The CN stated when she began reviewing MDS assessments for the facility, the assessments were already late, so she was trying to bring the assessments current. The CN stated she was not able to complete all MDS assessments yet, but she was continuously working to ensure they were all current. The CN stated it was her expectation that all MDS assessments were completed timely. The CN stated if an MDS assessment was not completed timely, it could affect a resident since their care plan needs may not be updated. Record review of the facility's policy titled, Electronic Transmission of the MDS, dated November 2019, revealed the following:Policy Statement:All MDS assessments (e.g., admission, annual, significant change, quarterly review, etc.) and discharge and reentry records are completed and electronically encoded into our facility's MDS information system and transmitted to CMS' iQIES Assessment Submission and Processing (ASAP) system in accordance with current OBRA regulations governing the transmission of MDS data.Policy Interpretation and Implementation:I. All staff members responsible for completion of the MDS receive training on the assessment, data entry, and transmission processes, in accordance with the MDS RAI Instruction Manual, before being permitted to use the MDS information system. A copy of the MDS RAI Instruction Manual is maintained by the resident assessment coordinator.2. Staff members are trained on updates/revisions to the MDS form and software upgrades as they are released. Such training is provided by the staff development director and/or computer software vendor.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure all PASARR Level I residents with mental illness were provided with an accurate PASRR Level I for 1 of 24 residents (Resident #7) reviewed for PASARR screening, in that: Resident #7 did not have an accurate and updated PASARR Level 1 assessment, reflecting a diagnosis of mental illness. This failure could place residents, with an inaccurate PASARR Level 1 and no PASARR Level 2 Evaluation, at risk for not receiving care and services to meet their needs. Findings included: Record review of Resident #7's electronic face sheet, dated 01/15/2026, revealed a [AGE] year-old male admitted on [DATE]. The face sheet included the following diagnoses: Cerebral Cryptococcosis (primary), also known as cryptococcal meningitis (severe fungal infection of the brain and spinal cord tissues, leading to symptoms like severe headache, fever, confusion, and stiff neck), schizoaffective disorder, bipolar type (a chronic mental illness combining symptoms of schizophrenia (hallucinations, delusions, disorganized thinking) with symptoms of bipolar disorder (manic episodes with high energy, irritability, impulsivity, and sometimes depressive episodes), altered mental status, unspecified (change in thinking, awareness, or behavior); and major depressive disorder, single episode, severe without psychotic features (a mood disorder that causes a persistent feeling of sadness and loss of interest). Record review of Resident #7's Annual MDS, dated [DATE], under section I (Active Diagnosis), indicated Resident #7 had a psychotic/mood disorder of schizophrenia. Additionally, under Section C Cognitive Patterns, Resident #7's MDS revealed a BIMS of 11, indicating the resident was moderately cognitively impaired. Record review of Resident #7's care plan, dated 11/23/2024, under Diagnoses indicated Resident #7 had a diagnosis of major depressive disorder and schizoaffective disorder. Additionally, the care plan included a focus area that began on 12/22/2022 which stated, Well-Being: has a psychosocial well-being problem r/t ineffective coping, Lack of motivation, Social isolation., with a goal dated 01/15/2025 which stated, will effectively cope with his/her feelings of (isolation, unhappiness, anger, loss) by the review date., with the interventions that included the following: Allow the resident time to answer questions and to verbalize feelings perceptions, and fears. Encourage participation from resident who depends on others to make own decisions. Record review of Resident #7's physician's Order Summary, dated as of 01/15/2026, revealed under Diagnoses major depressive disorder, single episode, severe without psychotic features and schizoaffective disorder, bipolar type. Resident #7 was prescribed zyprexa oral tablet 10 mg (olanzapine) (give 10 mg by mouth at bedtime) related to schizoaffective disorder, bipolar type, and paxil tablet 30 mg (paroxetine hcl) (give 60 mg by mouth at bedtime) related to major depressive disorder, single episode, severe without psychotic features. Record review of Resident #7's Preadmission Screening and Resident Review, Evaluation Report, (form 1014) dated 10/09/2020 revealed under section 1, Documentation Used to Confirm PASARR Qualifying Diagnosis: No qualifying diagnosis found on CARE, E View, Smart Care. There were no additional PASRR Level 1 screenings provided by the facility for Resident #7. There were no additional documents provided to suggest Resident #7 had a current and updated PASRR Evaluation. Record review of Resident #7's Preadmission Screening and Resident Review, Evaluation Short Form, dated 10/21/2020, revealed an uncompleted evaluation form, with all sections uncompleted. There were no additional PASRR screenings provided by the facility for Resident #7. There were no additional documents provided to suggest Resident #7 had a current and updated PASRR Evaluation. Record review of Resident #7's Diagnosis Report, dated 01/15/2025, revealed the following under Diagnosis: Major Depressive Disorder Single Episode, Severe Without Psychotic Features with an onset date of 08/12/2021 and Schizoaffective Disorder, Bipolar Type with an onset date of 11/7/2022. During an interview on 01/17/2026 at 11:00 a.m., the ADM stated the MDS nurse was responsible for ensuring PASRR screenings were accurate upon admission, and the MDS nurse (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was also responsible for requesting an updated PASRR screenings when a resident received a new mental illness diagnosis. The ADM stated the facility did not currently have an MDS nurse. The ADM stated she was currently responsible for ensuring PASRR screenings were accurate and completed, and the facility's SW was also assisting with PASRR screenings. The ADM stated she was not aware Resident #7 did not have an accurate PASRR screening, reflecting the resident's mental illness diagnoses of Schizoaffective Disorder, Bipolar type, and Major Depressive Disorder. The ADM stated these diagnoses qualified as a mental illness and should have been reflected on Resident #7's PASRR screening. The ADM stated PASRR screenings were reviewed during the admission process and should have been updated if any changes arose. The ADM stated it was her expectation for all residents' PASRR screenings to be accurate. The ADM stated she planned to request an updated PASRR screening for Resident #7. The ADM stated she and the SW received training on PASRR. The ADM stated if a resident's PASRR screening was not accurate, the resident may not have received the services for which they may qualify. During an interview on 01/17/2026 at 11:30 a.m., the SW stated she was responsible for auditing PASRR screenings, at times, but she was not responsible for ensuring PASRR screening were completed. The SW stated she assisted the ADM with reviewing PASRR screenings upon admission since the facility did not currently have an MDS nurse. The SW stated the MDS nurse was usually responsible for PASRR screenings and ensuring they were completed and accurate. The SW stated she was not aware Resident #7's PASRR screening did not reflect the resident's mental illness diagnoses. The SW stated Schizoaffective Disorder, Bipolar type and Major Depressive Disorder qualified as mental illnesses and should have been reflected on Resident #7's PASRR screening. The SW was not aware a PASRR screening should be updated if a new mental illness diagnosis was received for a resident. The SW stated she received training on PASRR. The SW stated she planned to review the PASRR screening for Resident #7, and she would ensure it was updated to reflect the resident's mental illness diagnosis. The SW stated it was important for a resident to have an accurate PASRR screening to ensure the resident received all services from which they could benefit. Record review of the facility's policy titled, Behavioral Assessment, Intervention and Monitoring, dated March 2019, revealed the following: Policy Statement:I. The facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care.6. The facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care. Policy Interpretation and Implementation:Assessment5. New onset or changes in behavior that indicate newly evident or possible serious mental disorder, intellectual disability, or a related disorder will be referred for a PASARR Level II evaluation.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675329	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Levelland Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide food that was palatable for 2 of 2 meals reviewed for palatability. The facility failed to provide food that was palatable for 1 of 3 food forms served (puree) at 2 of 2 meals observed (01/14/26 lunch and 01/15/26 lunch). This failure could place residents at risk of decreased food intake, hunger, and unwanted weight loss. Findings included: During an observation on 01/14/26 at 11:26 a.m., [NAME] A was preparing a puree meal. Observation revealed pureed chicken and broccoli runny with pea size chunks. Surveyor tasted puree chicken and puree broccoli, both had chunks that had to be chewed. During an observation of a puree diet test tray on 01/15/26 at 12:35 p.m. observed runny salisbury steak and Prince [NAME] vegetable blend and both had visible pea size chunks. Surveyor taste test of pureed Salisbury steak and Prince [NAME] vegetable blend revealed both had pea size chunks that had to be chewed. During an interview on 01/15/26 at 12:48 p.m., [NAME] A stated pureed should be smooth, like baby food. She stated a pureed diet was for residents who had a hard time chewing or swallowing regular textured food. She stated she was trained on how to prepare puree meals. She stated the potential negative outcome could be the resident choking. During an interview on 01/16/26 at 09:35 a.m., the DM stated she was responsible for training staff, and all staff were trained to prepare puree diet. She stated pureed should be smooth like baby food. She stated residents were on puree diet because they were having trouble chewing, swallowing or teeth problems. She stated the potential negative outcome could be choking or pocketing food. During an interview on 01/16/26 at 10:00 a.m., the ADM stated the DM and dietitian trained all staff on how to prepare pureed diets. She stated puree should be smooth with no chunks. She stated residents were on a puree diet because they could not chew food. She stated the potential negative outcome could be residents choking and weight loss. Record review of the facility policy titled Nutrition Policies and Procedures, dated September 2025, revealed the following documentation: Subject: Diet Definitions.2. b. You may need to add liquid such as broth, juice, or milk as appropriate to make a fluffy, mashed potato like consistency.c. You may need to add thickener to produce a fluffy, mashed potato like consistency.e. Blenderize until there are no small pieces of lumps in the food. f. Final product should hold its shape (not runny) and have a fluffy, moist consistency with no lumps.		

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

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NAME OF PROVIDER OR SUPPLIER Levelland Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 210 West Ave Levelland, TX 79336	
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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 reviewed for dietary services, in that: The facility failed on 01/14/26 to seal and date food stored in the refrigerator. This failure could place residents at risk for food contamination and foodborne illness. Findings included: The following observation was made on 01/14/26 at 09:27 a.m. during the initial tour of the kitchen: Bag of tortillas with no label and no date. Bowl of chili with lid not sealed. During an interview on 01/15/26 at 12:48 p.m., [NAME] A stated all food in the refrigerator should be sealed, labelled, and dated. She stated it was everyone's responsibility to seal, label and date food stored in the refrigerator. She stated she received training on how to properly store food in the refrigerator. She stated the purpose of dating food was to know when it needed to be thrown out. She stated the purpose of sealing food was to prevent bacteria. She stated the potential negative outcome could be residents getting sick from spoiled food. During an interview on 01/16/26 at 09:35 a.m., the DM she stated all food items in the refrigerator should be labelled, sealed, and dated. She stated all staff received training on how to properly store food. She stated the purpose of labelling and dating food was to know how long it was in the refrigerator and when to dispose of the food. She stated all staff were responsible for sealing, labeling, and dating food placed in refrigerator. She stated food not sealed could grow bacteria. She stated the potential negative outcome could be food contamination and residents getting sick from spoiled food. During an interview on 01/16/26 at 10:00 a.m., the ADM stated all staff were responsible for making sure food put in the refrigerator was properly sealed, labelled, and dated. She stated all staff received training on how to properly store food in the refrigerator. She stated the potential negative outcome could be food spoilage, foodborne illness, and infection control. Record review of the facility's policy, titled Food Receiving and Storage, dated revised November 2022, reflected the following: Policy Statement: Foods shall be received and stored in a manner that complies with safe food handling practices. Policy Interpretation and Implementation: .Refrigerated/Frozen Storage1. All foods stored in the refrigerator or freezer are covered, labeled, and dated (use by date) .7. Refrigerated foods are labeled, dated, and monitored so they are used by their use-by date, frozen or discarded.		