STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675534	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wheeler Nursing & Rehabilitation	1000 S Kiowa St Wheeler, TX 79096

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to, in accordance with accepted professional standards and practices, maintain medical records on each resident that were complete, accurately documented, readily accessible, and systemically organized for 1 of 5 residents (Resident #1) reviewed for medical records. The facility failed to ensure RN A accurately documented the ordered care of suprapubic catheter care for Resident #1 on 03/18/2026, and 04/04/2026. This failure could place residents at risk of having records that did not reflect their current status or needs.Findings included: Record review of Resident #1's admission record, dated 04/23/2026, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included, but were not limited to Quadriplegia, C1-C4 (spinal cord injury resulting in paralysis of all four limbs), cognitive communication deficit (communication and memory impairment) and personal history of urinary tract infections. Record review of Resident #1's Quarterly MDS Assessment, dated 03/05/2026, revealed a BIMS of 15 out of 15, which indicated cognition was intact. In Section H of the MDS it reflected Resident #1 has an indwelling catheter (including suprapubic catheter). Record review of Resident #1's care plan, dated 04/03/2026, revealed the resident had an indwelling catheter due to neuromuscular dysfunction of bladder, quadriplegic with goals to show no signs or symptoms of urinary infection and catheter care every shift.The resident was resistive to care related to adjustment of nursing home with goals for the resident to cooperate with care. Record review of Resident #1's active physician's orders reflected the following:Clean suprapubic foley catheter site and pat dry, apply split gauze every day shift for preventative and catheter care. Record review of Resident #1's Wound Administration Record for 03/01/2026 through 03/302026, reflected the following:Clean suprapubic foley catheter site and pat dry, apply split gauze every day shift for preventative and catheter care.03/01/2026-03/17/2026, reflected day shift conducted the care, 03/18/2026, no documentation of care was recorded. 03/19/2026 through 03/30/2026, documentation reflected day shift conducted the care. Record review of Resident #1's Wound Administration Record for 04/1/2026-04/23/2026, reflected the following:Clean suprapubic foley catheter site and pat dry, apply split gauze every day shift for preventative and catheter care: 04/01/2026-04/03/2026, reflected day shift conducted the care, 04/04/2026, no documentation of care was recorded. 04/05/206-04/23/2026, documentation reflected day shift conducted the care. During an interview on 04/23/2026 at 9:45 AM, Resident #1 reported no concerns regarding care. Resident #1 was unable to confirm whether care had been provided but stated everything was going ok. During an attempted interview on 04/23/2026 at 4:45 PM, Resident #1 did not acknowledge or respond to questions related to care and did not engage with this writer. During an interview on 04/24/2026 at 11:50 AM, RN A stated she worked on the day shift on 03/18/2026, and 04/04/2026. RN A stated Resident #1 intermittently declined care when it was offered so she would leave her documentation window open until the care was provided. RN A stated on those two dates she failed to close the documentation window after the care was provided. RN A stated if a resident refused care by the end of her shift, she should have documented that the care was refused. RN A stated she (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	received a verbal counseling and reeducation for failing to complete documentation. RN A stated failure to accurately document care could result in staff being unaware the care was completed. During an interview with MDS LVN, on 04/24/2026 at 12:00 PM, the MDS LVN, who also served as the Assistant Director of Nursing, stated RN A should have documented the care provided. The MDS LVN stated Resident #1 would decline care when offered, requiring staff to reattempt care throughout their shift. The MDS LVN stated RN A left the documentation window open in the clinical record and failed to return to complete the entry. The MDS LVN stated the negative outcome of incomplete documentation was the staff may not be aware of the residents' current status. The MDS LVN further stated, if it was not documented, then it would be considered that it didn't happen. During an interview with the DON on 04/24/2026 at 12:04 PM, the DON stated RN A should have documented the care provided. The DON stated Resident #1 would decline care when it was offered and it would cause the nursing staff to continually return to reattempt care until completed. The DON stated RN A should have closed out her documentation once care was provided or document the care was refused. The DON stated nurses were responsible for ensuring their documentation was complete, and she was responsible for ensuring documentation was accurate. Record review of the facility's policy Documentation, dated 02/13/2007, reflected the following:The facility will maintain complete and accurate documentation for each resident on all appropriate clinical records sheets.