

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: 675534	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2025
NAME OF PROVIDER OR SUPPLIER Wheeler Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 the professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen sanitation. 1. The facility failed to ensure proper hand hygiene and glove use was practiced. These failures could place residents who ate food served by the kitchen at risk of food-borne illness. Findings include: In an observation and interview on 8/26/25 at 12:05 pm [NAME] A was observed with gloved hands to touch food trays, the kitchen prep table, and serving utensils. [NAME] B picked up a tortilla with tongs, placed it on the plate filled the tortilla with meat and then folded the tortilla over using her hand. [NAME] B then continued to pick up serving utensils and plated the rest of the foods. [NAME] A did not wash her hands or change her gloves. [NAME] A stated she realized she had used her hand and stated she had just forgotten to use the tongs. She stated the consequence of touching food was food borne illness. In an interview on 6/24/24 at 2:20 PM, the DM stated she expected all staff to use tongs to serve bread products. The DM stated this could cause cross contamination. The DM stated she was responsible for training staff, and she would retrain them. Record Review of the facility policy and procedure, dated 2016, titled Sanitation/Infection Control documented employees are to wash hands prior to handling food, between handling cooked and uncooked food, after touching objects that may be a source of contamination. Record Review of the facility policy and procedure, dated 2016, titled Food Production and Meal Service documented serving utensils should be used to handle all foods as appropriate.		

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the assessment accurately reflected the resident's status for 1 (Resident #2) of 12 residents reviewed for accuracy of assessments. On Resident #2's MDS the facility inaccurately coded Resident #2 as receiving anticoagulant medication. This failure could place residents at risk of not receiving necessary care. Findings Included: Record review of Resident #2's admission record dated 08/27/25 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, hyperlipidemia (high cholesterol), orthostatic hypotension (form of low blood pressure that happens when standing after sitting or lying down), dysphagia (difficulty producing speech), and chest pain. Record review of Resident #2's quarterly MDS assessment revealed a completion date of 08/25/25. Section C (Cognitive Patterns) revealed a BIMS score of 15 which indicated the resident's cognition was intact. Section N revealed Resident #2 was receiving anticoagulant medication. Record review of Resident #2's care plan completed on 8/21/25 revealed Resident #2 was on anticoagulant therapy. Record review of Resident #2's active order summary report dated 08/26/25 revealed no order for anticoagulant medication. The report did reveal the following order: Aspirin Tablet EC (enteric coated) 81 MG Give 1 tablet by mouth one time a day for Preventative .During an interview on 08/28/25 at 09:54 AM, the MDS LVN stated she was responsible for completing MDS assessments. She stated she used the RAI manual as her policy when completing MDS assessments. When asked if aspirin should be coded as an anticoagulant in section N of the MDS she said yes it should. When she was shown a passage in the RAI which indicated aspirin was not to be coded as anticoagulant, she said, Huh, well ok! I did not know that. The MDS LVN could not think of a negative outcome for residents if aspirin was inaccurately coded as an anticoagulant. During an interview on 08/28/25 at 10:06 AM, the DON stated that the MDS LVN was responsible for MDS assessments. She stated a negative outcome of an inaccurate MDS could be reduction in funding and it could impact improper care for residents because the care plan was based on the MDS. During an interview on 08/28/25 at 10:08 AM, LVN A stated that she was the charge nurse for hall where Resident #2 resided. LVN A stated that the MDS LVN was responsible for MDS assessments and if a MDS was incorrectly coded, a resident's care plan could be affected which could negatively impact the residents' medications. During an interview on 08/28/25 at 10:10 AM, the ADM stated the MDS LVN was responsible for completing MDS assessments. She stated MDS assessments affected facility funding as well as direct resident care plans. The ADM stated having an inaccurate MDS could therefore negatively impact the care a resident received. Record review of the Long-Term Care Facility RAI 3.0 User's Manual Version 1.18.11 dated October 2023 revealed the following: . N041 5: High-Risk Drug Classes: Use and Indication . N041 5E1. Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin): Check if an anticoagulant medication was taken by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). Coding Tips and Special Populations . Do not code antiplatelet medications such as aspirin/extended release, dipyridamole, or clopidogrel as N041 5E, Anticoagulant.		

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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 resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 (Resident #2) of 12 residents reviewed for care plans. The facility inaccurately care planned that Resident #2 was receiving Anticoagulant therapy. This failure could place residents at risk of not receiving desired and necessary care and treatment. Findings Included: Record review of Resident #2's admission record dated 08/27/25 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, hyperlipidemia (high cholesterol), orthostatic hypotension (form of low blood pressure that happens when standing after sitting or lying down), dysphagia (difficulty producing speech), and chest pain. Record review of Resident #2's quarterly MDS assessment revealed a completion date of 08/25/25. Section C (Cognitive Patterns) revealed a BIMS score of 15 which indicated the resident's cognition was intact. Section N revealed Resident #2 was receiving anticoagulant medication. Record review of Resident #2's care plan completed on 8/21/25 revealed Resident #2 was on anticoagulant therapy. Record review of Resident #2's active order summary report dated 08/26/25 revealed no order for anticoagulant medication. The report did reveal the following order: Aspirin Tablet EC (enteric coated) 81 MG Give 1 tablet by mouth one time a day for Preventative. During an interview on 08/28/25 at 9:54 AM, the MDS LVN stated that she was responsible for completing care plans along with the DON. When asked to look at Resident #2's care plan, she stated that it was wrong based on the RAI manual, that she should not have coded him as using an AC, but she thought aspirin was an AC. She stated a possible negative outcome for not having a correct care plan could be improper care. During an interview on 08/28/25 at 10:08 AM, the DON stated it was her and the MDS LVN's responsibility to ensure care plans were completed accurately. She stated that a possible negative outcome for not having the correct information in the care plan would be wrong treatment for residents and improper care. During an interview on 08/28/25 at 10:10 AM, the ADM stated that the MDS LVN and the DON were responsible for making sure the care plans were accurate. She stated a possible negative outcome for not having a care plan that was correct would be that care would not be right for that resident. Record review of the facility's policy titled "Comprehensive Care Plans" dated February 13, 2007, revealed in part the following. The facility will develop a comprehensive care plan for each resident that includes measurable short-term and long-term objectives and timetables to meet a residents medical, nursing and mental and psycho-social needs that are identified in the comprehensive assessment. 5. The comprehensive care plan will be maintained on the resident's clinical record and will be made available to all direct care staff. Record review of the Long-Term Care Facility RAI 3.0 User's Manual Version 1.18.11 dated October 2023 revealed the following: . N041 5: High-Risk Drug Classes: Use and Indication . N041 5E1. Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin): Check if an anticoagulant medication was taken by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). Coding Tips and Special Populations . Do not code antiplatelet medications such as aspirin/extended release, dipyridamole, or clopidogrel as NO41 5E, Anticoagulant.		