STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675009	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Coleman Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2713 S Commercial Ave Coleman, TX 76834	

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45732 Based on observation, interview, and record review the facility failed to ensure its medication error rates were not 5% or greater. The facility had a medication error rate of 8%, based on 2 errors out of 25 opportunities which involved 2 of 14 residents (Resident #134 and Resident #22) reviewed for medication administration and medication errors. 1. LVN A on 11/24/2024 administered 1 tablet of buspirone (medication used to treat anxiety) 5mg to Resident #134 when the physicians order date 04/19/2024 called for 2 tablets. 2. LVN B on 11/24/2024 administered 1 tablet of dicyclomine (medication used to relax abdominal muscles to reduce cramping) 20mg to Resident #22 when the physicians order dated 11/14/2024 called for 2 tablets. These failures could place residents at risk for not having the intended therapeutic benefit. The findings included: 1. Review of Resident #134's electronic face sheet revealed an [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included: brain bleed, cognitive decline, and diabetes. Review of Resident #134's quarterly MDS assessment dated [DATE] revealed a BIMS score of 15 which indicated no cognitive impairment. Further review of MDS Section N revealed antianxiety medications taken within the last seven days. Review of Resident #134's care plan initiated 03/28/2024 revealed, Focus: The resident uses anti-anxiety medications r/t anxiety (Buspirone). Goal: The resident will be free from discomfort or adverse reactions related to anti-anxiety therapy. Interventions: Administer anti-anxiety medications as ordered by physician. Monitor for side effects and effectiveness. Review of Resident #134's electronic physicians orders revealed: Buspirone tablet 5mg Give 2 tablets by mouth three times a day for anxiety, order date 04/19/2024. Review of Resident #134's pharmacy card containing buspirone 5mg tablets revealed: Buspirone tablet 5mg Give 2 tablets by mouth three times a day for anxiety. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675009	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coleman Healthcare Center	2713 S Commercial Ave Coleman, TX 76834

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 11/24/24 at 11:00 AM, LVN A prepared and administered Metamucil Smooth Texture Oral Powder 28.3 % 1 scoop, hydralazine Oral Tablet 50mg 1 tablet, and buspirone tablet 5mg 1 tablet to Resident #134. During an interview on 11/24/24 at 12:30 PM, LVN A stated she had only performed the medication pass a few times and she just wasn't paying attention and missed it. She stated she should have checked the five rights of medication (right resident, right medication, right dosage, right time, and right method route of administration) prior to passing the medications. LVN A stated this could cause Resident # 134 to not get the desired anxiety relief. 2.Review of Resident #22's electronic face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included: adnominal hernia with obstruction, lung disease, and heart failure. Review of Resident #22's quarterly MDS assessment dated [DATE] revealed a BIMS score of 11 which indicated moderate cognitive impairment. Review of Resident #22's care plan initiated 08/29/2024 revealed, Focus: Resident is at risk related to alteration in bowel elimination. Goal: Resident will have decreased episodes of constipation. Interventions: Dicyclomine per MD orders. Review of Resident #22's electronic physicians orders revealed: Dicyclomine Tablet 20mg Give 2 tablet by mouth four times a day for treatment of irritable bowel syndrome, order date 11/14/2024. Review of Resident #22's pharmacy card containing Dicyclomine 20mg tablets revealed: Dicyclomine Tablet 20mg Give 2 tablet by mouth four times a day. During an observation on 11/24/24 at 11:30 AM, LVN B prepared and administered Dicyclomine Tablet 20mg 1 tablet to Resident #22. During an interview on 11/24/24 at 12:45 PM, LVN B stated she was nervous and didn't check the dose for Resident #22. She stated she did not know the negative effect because she did not know what that medication was used to treat. During an interview on 11/25/24 at 04:15 PM, the DON stated that the failure was due to nurses not paying attention. He stated the orders where entered clearly and this should not have happened. The DON stated the negative effect on residents was residents not getting desired dose of medication to properly treat and maintain their disease process. Review of the facility policy titled, Medication Administration, revised 7/8/24, revealed in part: Medications are administered in a safe and timely manner and as prescribed. Policy interpretation and implementation. 2. The director of nursing services supervises and directs all personnel who administer medications and/or have related functions . 4. Medications are administered in accordance with prescriber orders, including any required time frame . 6. Medication errors are documented, reported, and reviewed by the QAPI committee to inform process changes and or need for additional staff training . 10. The individual administering the medication checks the label three times to verify the right resident, right medication, right dosage, right time, and right method route of administration before giving the medication .

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NAME OF PROVIDER OR SUPPLIER: Coleman Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 2713 S Commercial Ave Coleman, TX 76834	

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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 0761

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

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.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 45732

Based on observation, interview and record review, the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles and included the appropriate accessory and cautionary instructions for 1 of 2 medication carts (Hall 300/400 medication cart) and 3 of 35 residents (Resident #2, #18 and #29)) reviewed for medication labeling and storage.

The Hall 300/400 medication cart contained a Humulin R flex pen insulin for Resident #2 with an open date of 10/20/2024, making it past 28 days meaning the medication had expired.

The Hall 300/400 medication cart contained an Insulin Glargine flex pen insulin for Resident #18 with an open date of 10/18/2024, making it past 28 days meaning the medication had expired.

The Hall 300/400 medication cart on 11/24/2024 contained a Lantus flex pen insulin for Resident #29 with an open date of 10/12/2024, making it past 28 days meaning the medication had expired and no pharmacy label with the resident's name written in marker and an Insulin Lispro flex pen insulin for Resident #29 with no open date and no label with the resident's name written in marker.

These failures could place residents at risk of receiving expired medications.

Findings included:

Review of the electronic face sheet for Resident #2 revealed an admitted [DATE]. Resident was a [AGE] year-old male with a diagnosis of diabetes, heart failure, and multiple sclerosis.

Review of the electronic physician's orders for Resident #2 revealed orders for Humulin R Injection Solution 100 UNIT/ML Inject as per sliding scale: if 0 - 60 Notify MD and start hypoglycemic protocol; 61 - 150 = 0; 150 - 200 = 3 units; 201 - 250 = 6 units; 251 - 300 = 8 units; 301 - 350 = 10 units; 351 - 400 = 14 units; 401 - 999 = 0 Notify MD, subcutaneously before meals and at bedtime.

Review of the electronic face sheet for Resident #18 revealed an admitted [DATE]. Resident was a [AGE] year-old female with a diagnosis of diabetes, depression, and kidney failure.

Review of the electronic physician's orders for Resident #18 revealed orders for Insulin Glargine Subcutaneous Solution 100 Unit/Ml inject 20 unit subcutaneously one time a day.

Review of the electronic face sheet for Resident #29 revealed an admitted [DATE]. Resident was a [AGE] year-old female with a diagnosis of diabetes, breast cancer, and amputation.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the electronic physician's orders for Resident #29 revealed orders for Insulin Lispro Subcutaneous Solution Pen-Injector 100 UNIT/ML Inject as per sliding scale: if 0 - 150 = 0 Notify MD if Blood Sugar less than 60 or greater than 400; 150 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; subcutaneously before meals and at bedtime and Lantus Subcutaneous Solution Pen-Injector 100 Unit/Ml inject 6 unit subcutaneously at bedtime. During on observation on 11/24/2024 at 09:30 AM of the Hall 300/400 medication cart contained a Humulin R flex pen insulin for Resident #2 with an open date of 10/20/2024, an Insulin Glargine flex pen insulin for Resident #18 with an open date of 10/18/2024, a Lantus flex pen insulin for Resident #29 with an open date of 10/12/2024 and no pharmacy label with the residents name written in marker, and an Insulin Lispro flex pen insulin for Resident #29 with no open date and no label with the resident's name written in marker. During an interview on 11/24/24 at 01:27 PM, LVN A stated insulin vials and pens should have been dated when opened and discarded after 28 days. She stated all vials and pens should have the original pharmacy label. She stated it was each nurse's responsibility to ensure medications were labeled and not expired. During an interview on 11/25/24 at 12:12 PM, the DON stated insulin vials and pens should have been dated when opened and labeled with expiration date. He stated insulin expired within 28 days of opened date. He stated it was the nurse's responsibility to ensure that medications were not expired prior to giving them. DON stated he did not know why the medications where still on the cart and that this failure could lead to residents receiving expired medications. Review of the policy titled, Storage of Medications, last revised July 2024 read in part: Policy Statement: The facility store all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation: 2, Drugs and biologicals are stored in the packaging, containers or other dispensing systems in which they are received .3. The nursing staff is responsible for maintain medication storage .4. Drug containers that have missing, incomplete, improper, or incorrect labels shall be returned to the pharmacy for proper labeling before storing. 5. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. Review of the facility policy titled, Medication Administration, revised 7/8/24, read in part: Medications are administered in a safe and timely manner and as prescribed. Policy interpretation and implementation. 12. The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container . 17. Insulin pens are clearly labeled with the resident's name or other identifying information. Prior to administering insulin with an insulin pen, the nurse verifies that the correct pen is used for that resident.