STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676423	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE HALLMARK	4718 HALLMARK DR HOUSTON, TX 77056

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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to treat each resident with respect and dignity that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 1(Resident #23) of 12 residents reviewed for resident rights in that: -CNA BC was standing while feeding Resident #23. This failure could place all residents who need assistance with eating at risk of a decline in their quality of life and lowered self-esteem. Findings include: Record review of Resident #23's face sheet revealed she was a [AGE] year old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Her [DIAGNOSES REDACTED]. Record review of Resident #23's MDS assessment dated [DATE] revealed a BIMS score of 7 out of 15 indicating severely impaired cognition. She required extensive assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. She required limited assistance with eating. She was frequently incontinent of bowel and bladder. Further review of Resident #23's MDS section K- swallowing/nutritional status revealed no documentation of any problems with swallowing. Record review of Resident #23's current electronic Physician order [REDACTED]. Record review of Resident #23's comprehensive care plan dated 01/28/20 revealed in her ADL care plan an intervention for eating: supervision/stand by and set up assistance with eating. Observation on 03/04/20 at 12:20 p.m. of Resident #23 revealed she was sitting in wheelchair at the dining room table. CNA BC went over to Resident #23's table and began to feed her ice cream while standing up over the resident. She was not interviewable. Interview on 03/04/20 at 1:55 p.m. with CNA BC, she said the reason she stood while feeding Resident #23 ice cream was in case the resident started to cough on her. CNA BC said if someone would stand over her while feeding her, it would probably make her feel bad and disrespected. CNA BC said no one had explained to her why she should not stand while feeding a resident. Interview on 03/06/20 at 11:43 a.m. with CNA I, she said she had been trained to sit at eye level when feeding the residents in order to observe the resident during feeding to ensure they were not chocking. CNA I said standing while feeding a resident was demeaning. Interview on 03/05/20 at 10:30 a.m. with the DON, she said staff should be feeding residents at eye level, assessing and ensuring the resident was not having any issues with choking or eating that would need to be reported as a change in their health status.
F 0640 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to transmit a resident assessment within the required time frame for 2 of 12 Residents (CR #2 and CR #1) reviewed for data encoding and transmission in that: -CR #1 was discharged from the facility on 12/31/2019 and no Discharge MDS was created. -CR #2 was discharged from the facility on 11-1-2019 and the Discharge MDS was not completed correctly for transmittal. These failures could affect any Residents who have been discharged in the last 6 months and put them at risk of not having their assessments transmitted timely. Findings Include: CR#1 Record review of CR #1's admission sheet revealed she was a [AGE] year-old female originally admitted to the facility on [DATE] and readmitted on [DATE]. Her [DIAGNOSES REDACTED]. She was discharged on [DATE]. Record review of CR #1's EMR revealed the Discharge summary documented CR#1 was discharged on [DATE]. Further review of the EMR revealed the Discharge MDS assessment was not initiated or completed to where the assessment would be visible, coded, or transmitted as of 3/6/2020. During interview with LVN B on 03/06/20, at 11:28 a.m. she said did not complete the discharge MDS for CR#1. She said the Resident stayed past her days and she forgot to complete the discharge summary once the Resident was discharged . CR #2 Record review of CR #2's admission sheet revealed she was a [AGE] year-old female admitted to the facility on [DATE] and discharged on [DATE]. Her [DIAGNOSES REDACTED]. Record review of CR #2's EMR revealed the resident's Discharge MDS assessment was initiated and exported on 11/1/2019. The Discharge MDS was rejected on 11/12/2019. The Discharge MDS assessment was not corrected and re-submitted to where the assessment would be visible, coded, or transmitted as of 3/6/2020. During interview with the DON on 3/06/2020 at 10:55 a.m. she said LVN B submitted the discharge MDS, but it was rejected. She said CR #2's MDS rejection did not show up' in their system as rejected. She said LVN B should have followed up. She said the billing department was also supposed to follow-up and triple check if any assessments were missed. During interview with LVN B on 03/06/20, at 11:28 a.m. she said for CR#2 she entered some duplicate information on the original discharge MDS assessment and it was rejected. She said the system did not alert her of the error so the completion of the discharge MDS assessment was overlooked. Record review of the facility policy, MDS Protocol, dated 11/2017 read in part, .Purpose: Assure MDS is completed in a timely manner . Procedure: All MDS sections will be completed within 14 days of admission . Each portion of the MDS will be checked for accuracy and completion by individuals responsible .
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services including procedures to accurately administer medications to meet the needs of each resident for 2 of 12 residents (Resident #9 and # 15) reviewed for pharmacy services in that: -Resident #15's medication [MED] ([MED]) 2.5 mg was not in the facility. Staff were taking Resident #9's [MED] and administering it to Resident #15. This failure could affect all residents who receive medications with pharmaceutical recommendation. Findings include: Resident #9 Record review of Resident # 9's face sheet revealed a [AGE] year old female admitted to the facility on [DATE] with the following diagnoses; [MEDICAL CONDITION], hypertension, hearing loss, gastro-[MEDICAL CONDITION] reflux disease, [MEDICAL CONDITION], constipation, and vitamin D deficiency. Record review of Resident #9's Physician order [REDACTED].#9's Medication Administration Record [REDACTED]. Interview on 03/06/20 at 1:25 p.m. Resident #9 said she had been receiving her medications. Resident #9 was able to verbalize the dosage, name, and how often she took the medication [MED]. Resident #9's private sitter also interjected saying that Resident #9 had no complaints about not receiving her medications. Resident #15 Record review of Resident #15's face sheet revealed a [AGE] year old female admitted the facility on 02/27/19 and readmitted on [DATE] with the following Diagnoses: [REDACTED]. Record review of Resident #15's MDS assessment dated [DATE] revealed a BIMS score of 7 out of 15 indicating severely impaired cognition. She required extensive assistance of two staf with bed

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) mobility, transfer, dressing, eating, toilet use, and personal hygiene. She was totally dependent on two staff for locomotion on and off the unit. She had functional limitation in range of motion with impairment on one side to the upper and lower extremity. She was always incontinent of bowel and bladder. Record review of Resident #15's comprehensive care plan dated 11/08/19 revealed she was care planned for post [MEDICAL CONDITION]. Record review of Resident #15's Physician order [REDACTED]. Record review of Resident #15's MAR for the month of February 2020 revealed that RN B documented that Resident #15's medication [MED] 2.5 mg po at 8:00 a.m. was not given on the following days, [DATE]-02/28/20. Further review of Resident #15's MAR indicated [REDACTED]. Record review revealed that for the evening dose at 5:00 p.m. that LVN TT documented that resident was not given the medication [MED] 2.5 mg 02/29/20. Record review of Resident #15's MAR for the month of (NAME)2020 revealed that LVN TT documented that Resident #15 did not receive the medication [MED] 2.5 mg po morning dose at 8:00 a.m. or 5:00 p.m. on 03/01/20. Further review revealed that RN B documented that the medication [MED] 2.5 mg po was not given to Resident #15 for 8:00 a.m. for the following days: 03/03/20-03/05/20. Record review of a fax from the pharmacy to the NF to the attention of RN B dated 02/21/20 regarding Resident #15 read to please contact MD to call insurance for prior authorization for the medication [MED] 2.5 mg tablet quantity of 60 (sixty). Record review of the NF Clinical Notification Log dated 02/27/20 for Resident #15 read in part: need prescription for [MED]. Further review of Clinical Notification Log regarding Resident #15 dated 03/01/20 read in part: completely out of [MED] requires prior authorization/form in folder. Observation and interview of medication pass for Resident #15 on 03/05/20 at 8:50 a.m. with RN B revealed RN B said she was unable to administer the medication [MED] 2.5 mg po because the medication was not available. RN B said the medication [MED] was ordered and would be arriving at the facility on 03/05/20. RN B said Resident #15's medication [MED] 2.5 mg must have run out over the weekend. Interview on 03/05/20 at 12:05 p.m. with RN JJ said he had called the pharmacy last week but could not recall the exact day. RN JJ said the pharmacy said they would be delivering the medication [MED]. RN JJ said maybe there was a problem with Resident #15's insurance. RN JJ said he was borrowing medication from Resident # 9 who was also on [MED] 2.5 mg po. RN JJ said he never notified the DON or the other nurses that Resident #15 did not have the medication [MED] available. RN JJ said he just assumed that the nurse following him would call the pharmacy. RN JJ said he normally called the pharmacy for refills 3 days prior to a resident's medication running out because the pharmacy wouldsay they could not fill the prescription due to insurance reasons. RN JJ said it was important for Resident #15 to receive the medication [MED] to prevent [MEDICAL CONDITION] the same went for Resident #9 who had a [DIAGNOSES REDACTED]. There was no answer and the voice mailbox was full. Interview on 03/05/20 at 1:20 p.m. with Pharmacy Staff said Resident #15's medication [MED] 2.5 mg po was scheduled to be delivered to the facility on [DATE]. The Pharmacy Staff said the medication [MED] 2.5 mg was requiring a prior authorization for a refill from the physician. The Pharmacy Staff said a preauthorization was faxed over to the NF to the attention of RN B on 02/21/20. Another preauthorization was faxed to the NF on the 24th and 25th and twice on the 26th of February 2020. The Pharmacy Staff said before the medication [MED] 2.5 mg could be refilled, the physician had to call Resident #15's insurance company. Interview on 03/05/20 at 2:40. with Resident #15's Physician said she was aware of Resident #15 needing a preauthorization for the medication [MED] but did not know the resident was completely out of the medication [MED]. The physician said she gave the authorization for [MED] refill on 03/05/20. The Physician said Resident #15 was on the medication [MED] as a [MEDICATION NAME] and there were no lab draws associated with the medication [MED]. The Physician said there had not been any changes in Resident #15'scondition such as focal weakness that could mimic a stroke reported to her. Interview on 03/06/20 at 11:55 p.m. with RN B said she called the pharmacy everyday regarding residents' medications but did not remember the exact day she called for Resident #15. RN B said she never reached out to the DON regarding the refill for Resident #15's medication [MED] because she had already placed a call to the pharmacy prior. RN B said she had been working at the NF since January of 2020 and the nurse that she trained with told her to look in the reordering medication book to see what medications needed to be ordered. RN B said moving forward she would reach out to the DON if having difficulty in refilling a resident medication. RN B said she had been in-serviced by the DON to call the pharmacy a week ahead prior to the resident's last dose of medication to ensure no missed dose. Record review of RN B's Charge Nurse Performance Checklist revealed it was blank. Interview on 03/06/20 at 1:30 p.m. the DON said all new nurses were trained with tenured nurses on the unit along with the ADON and herself. The DON said the staff had been trained to call a week in advance of a resident's last medication dose to ensure there were no missed doses. The DON said the facility had an issue with the staff not calling the pharmacy in time with ordering medications for the resident's medication, but it had been over a year ago. The DON said the staff had been in-serviced that if there was a problem with pharmacy in reordering medications to notify her or the Administrator. The DON said herself or the Administrator would charge the cost to the NF so that a resident would continue to get their medication as ordered by the physician. Further interview with the DON said she had spoken to RN JJ who shared with her that he was borrowing the medication [MED] 2.5 mg from Resident #9 to give to Resident #15. Record review of the NF policy on Medication Administration dated 11/01/2017 read in part: .Resident refill request should be sent when medication is down to the last week .
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 kitchens in that: - Foods were not sealed, labeled and dated. - Foods that were expired were stored with unexpired foods. - A dirty pan was stored with clean pans. - Equipment was not cleaned. - Foods were not at the correct holding temperature. These failures had the potential to affect all residents who ate food prepared by the kitchen and could place them at risk of food borne illness and disease. Findings include: Observation of the kitchen on [DATE] beginning at 09:55 AM through 10:30 AM revealed the following. 4- Containers with fresh mozzarella cheese with an expiration date of [DATE] in the walk-in-cooler; 1-Box with summerberry stack cake that contained eggs and milk not dated in the free-standing freezer; 1- Open box with brownies not labeled or dated; 6- Cans of evaporated milk with an expiration date of [DATE] was found in the dry storage room; 1- Box that was labeled chicken breast but had what was identified by the Dietary Manager as pepperoni pizza, was not sealed, labeled, or dated in the walk-in-freezer; and pans with food particles were stored with clean pans. In an interview with the Dietary Manager on [DATE] at 10:25 AM she said Cook D took the unlabeled and undated food items and labeled them. She said she would have to check for expired food dates every day. Observation on [DATE] at 12:15 PM in the kitchenette on the North side of the second floor revealed the microwave had dried food particles in it. The refrigerator had tuna salad with a temperature of 53.5 degrees Fahrenheit. During an interview on [DATE] at 12:20 PM the Dietary Manager said they should always check the temperature of the menu items before service. She also said the microwave should be cleaned after every meal and she did not know why it was not cleaned. Record review of the facility's policy and procedures on Food Safety and Sanitation Storage dated 2013 revealed in part: Policy: All local state and federal standards and regulations are followed in order to assure a safe and sanitary food service department. Procedure: 4. - Food Storage - Foods are refrigerated and stored at or below 41 degrees Fahrenheit - Foods with expiration dates are used prior to the used by date on the package. - Canned and dry foods without expiration dates are used within six months of delivery or according to the manufacturer's guidelines. Care of the Storeroom 12-C Refrigerated, and frozen foods are dated upon delivery. Food with expiration dates are used prior to the date on the package. Canned and dry foods without expiration dates are used within six months of delivery or according to the manufacturer's guidelines. Canned goods should be dated, and staff should use the FIFO (first in/first out) method to rotate foods.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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 to include handwashing and to help prevent the development and transmission of communicable diseases and infections for 1 of 12 residents (Resident #15) reviewed for infection control in that: -RN B did not wash or sanitize hands after entering Resident #15's room or in between administering eye medications to Resident #15. This failure could affect all residents in the facility by placing them at risk for spread of infection and hospitalization . Findings include: Record review of Resident #15's face sheet revealed a [AGE] year old female admitted the NF on 02/27/19 and readmitted on [DATE] with the following Diagnoses:

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) [REDACTED]. Record review of Resident #15's MDS assessment dated [DATE] revealed resident had a BIMS score of 7out of 15 indicating severely impairedcognition. She required extensive assistance of two staff for bed mobility, transfers, dressing, eating, toilet use, and personal hygiene. She was totally dependent on two staff for locomotion on and off the unit. She had functional limitation in range of motion with impairment on one side to the upper and lower extremity. She was always incontinent of bowel and bladder. Record review of Resident #15's care plan dated 11/08/19 revealed that resident was being care planned for impaired visual function related to her [MEDICAL CONDITION] and was considered legally blind. Record of Resident #15's physician Order Summary Report revealed an order dated 10/31/19 for Dorzolamide HCL solution 2% instill one drop in left eye three times a day for [MEDICAL CONDITION]. Further record review revealed an order dated 10/30/19 for [MEDICATION NAME] solution 0.6% instill 1 drop in both eyes four times a day for dry eyes. Observation on 03/05/20 at 8:50 a.m. of Resident #15 revealed she was in her room resting in bed. She was non-interviewable. RN B was observed entering Resident #15's room with medications including 2 eye drop medications, Dorzolamide and lubricant eye drop. RN B was also carrying 2 sets of clean gloves. RN B did not wash or sanitize her hands before putting on gloves to administer the eye drop Dorzolamide to Resident #15's left eye. RN B gave Resident #15 her crushed po medications. When RN B was done administering the po medications, she then removed her soiled gloves and put on a new set of clean gloves without washing or sanitizing her hands. She then administered the lubricant eye drops one drop in each of Resident #15's eyes. RN B removed her gloves and exited resident room. Interview on 03/05/20 at 9:15 a.m. with RN B said she did not know she had to sanitize or wash her hands when she entered Resident #15's room or in between care because she had already sanitized her hands in the medication room. RN B said she was trained by a nurse on the unit and had been working at the NF since January of 2020. Interview on 03/05/20 at 10:30 a.m. with the DON said when administering eye drops, the nurse needs to wash their hands before administering care to a resident and in between care to avoid cross contamination. The DON said she had not done any in-service recently on administering eye drop medications. Further interview with the DON said all new nurses were trained by a tenured nurse on the nursing unit. Record review of the NF policy on Handwashing/Hand Hygiene revised (NAME)2015 read in part: .The facility considers hand hygiene the primary means to prevent the spread of infections .All personnel shall be regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections .Use hand hygiene before and after direct contact with residents .before and after removing gloves .hand hygiene is the final step after removing and disposing of personal protective equipment . Record review of the NF policy on Medication-Instillation of Eye Medication revised 12/2010 read in part: .Wash or sanitize hands .Retrieve the medication .Check the label on each eye medication against the MAR indicated [REDACTED].Wash or sanitize hands .Confirm the resident .Instill the medication .Wash or sanitize hands . Record review of https://www.cdc.gov/handhygiene/providers/index.html dated January 31, 2020 read in part, .Following are the clinical indications for hand hygiene: . Use an Alcohol-Based Hand Sanitizer Immediately before touching a patient After touching a patient or the patient's immediate environment After contact with blood, body fluids or contaminated surfaces Immediately after glove removal