

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676423	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/12/2024
NAME OF PROVIDER OR SUPPLIER The Hallmark		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37059</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents who were incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 1 resident (Resident #1) reviewed for incontinent care.</p> <p>The facility failed to ensure Resident #1's catheter bag was not maintained below the bladder.</p> <p>This failure could place residents at risk for pain, infection, injury, and hospitalization .</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet dated 7/12/24 revealed a [AGE] year-old female admitted to the facility on [DATE]. Resident #1 had diagnoses included: urinary tract infection, neuromuscular dysfunction of bladder (lacks bladder control due to brain, spinal cord or nerve problems), functional quadriplegic and hypertension (high blood pressure).</p> <p>Record review of Resident#1's admission quarterly assessment dated [DATE] revealed: Resident #1 had a BIMS score of 13 out of 15 indicating her cognition was intact. Further review revealed Resident #1 had an indwelling catheter.</p> <p>Record review of Resident #1's care plan dated 7/12/2024 revealed the following in part:</p> <p>Focus: [Resident #1 has a indwelling Catheter Neurogenic bladder (a condition that affects bladder function due to nervous system damage or disease) Date initiated 6/29/2021.</p> <p>Goal: Reduce the risk from catheter related trauma through review date. Date initiated 6/29/2021.</p> <p>Interventions: .Catheter: .Position catheter bag and tubing below the level of the bladder</p> <p>An observation on 7/12/2024 at 12:15 p.m. revealed Resident #1 was lying down in her bed. Resident #1's catheter bag and tubing was not visible on either side of her bed.</p> <p>During an interview on 7/12/2024 at 12:16 p.m., Resident #1 said she had a catheter. She said it should be hung on the side of her bed so it could drain. She called for assistance.</p> <p>(continued on next page)</p>

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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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation 7/12/2024 at 12:17 p.m. revealed Manager A came into the room, lifted the blankets that covered Resident #1 and discovered the catheter bag and tubing was in the bed. The catheter bag was half full without urine draining from the tubing.</p> <p>During an interview on 7/12/2024 at 12:20 p.m., Manager A said Resident #1's catheter was not draining. She said the catheter bag and tubing should have been hanging below her bladder to aid in the drainage and prevent backing up in the tube that could cause infection. She said Resident #1 returned from a sister facility earlier that day and the assigned nurse should have ensured the catheter was in the correct position.</p> <p>During an interview on 7/12/2024 R 12:33 p.m., Agency LPN A said she had worked with Resident #1 once approximately a month ago. She said she started her shift this morning (7/12/2024) at the sister facility. She said she did not remember if Resident #1 had a catheter. Agency LPN A said, after arriving to the facility, she went into Resident #1's room approximately an hour ago and to adjust Resident #1's oxygen and provide her with a snack. She said she did not check for a catheter. She said the catheter should have been positioned below her bladder so it could drain. She said if the urine did not drain, then the Resident was at risk for developing an infection. Agency LPN A said she was trained to receive report from staff before providing care each shift. She said she did not recall if she received report on Resident #1's catheter status or care.</p> <p>During an interview on 7/12/2024 at 12:44 p.m., CNA A said she saw Resident #1 at the sister facility earlier today (7/12/2024) and the resident had the catheter on. She said after she arrived at the facility today (7/12/2024), she had not checked on Resident #1. She said Agency LPN A should have ensured the catheter was in place. CNA A said if the catheter was not draining, the urine could back up in the tubing and could cause an infection.</p> <p>During an interview on 7/12/2024 at 12:49 p.m., the DON said the nurse should have made sure the catheter was draining. She said Resident #1 was at risk for infection when the catheter was not draining properly or positioned below her bladder. She said the nurses should have given report to each other so the nurse coming on shift was aware of resident needs. She said catheter care was a basic nursing skill that was within a nurse's scope of practice.</p> <p>Record review of facility policy Catheter Care, Urinary (not dated) revealed the following in part:</p> <p>Purpose</p> <p>The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections .</p> <p>Maintaining Unobstructed Urine Flow</p> <p>.3. Position the drainage bag lower than the bladder at all times to prevent urine from flowing back into the urinary bladder.</p>		