STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676423	A. Building B. Wing	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 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 observations, interviews and record reviews the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 3 of 3 residents (Residents #3, #20 and #36) and 2 of 2 (LVN A and LVN B) staff observed during medication administration. The facility failed to ensure staff Clarified any order that is incomplete, illegible, or presents any other concerns, prior to administering the medication for Resident #3, Resident #20 and Resident #36 on 03/18/2026. The failure could place residents at risk of receiving less than optimal results from their medication regimen. Findings included:Resident #3 Record review of Resident #3's undated admission record revealed a [AGE] year-old female with an admission on [DATE]. Resident #3 had diagnoses including multiple fractures (broken bones) of ribs and thoracic vertebrae (chest bones that protect the spinal cord) and cognitive communication deficit (difficulty with communication). Record review of Resident #3's Care Plan initiated on 02/18/2026 read, resident had pain in both legs. The interventions read, apply diclofenac (generic name for Voltaren) gel to both legs topically four times a day for pain. Record review of Resident #3's admission MDS dated [DATE] revealed a BIMS score of 12 with moderate cognitive impairment, meaning the resident had moderate memory, orientation, or decision-making challenges, often required increased assistance with daily activities. Record review of Resident #3's Physician Orders, dated 02/16/2026, revealed an active order of diclofenac gel 1%. Apply to affected area topically four times a day for pain. The order did not specify where to apply the gel over. Record review of Resident #3's Physician Orders, dated 02/18/2026, revealed an active order of polyethylene glycol 3350 oral (by mouth) powder 17 gm/scoop. Give 1 scoop by mouth daily for constipation. The order did not specify how much fluid to mix the powder with. During an observation on 03/18/2026 at 8:46 a.m., LVN A poured and mixed polyethylene glycol powder with an unmeasured amount of water and gave it to Resident #3. Further observation revealed LVN A prepared Voltaren gel and went to Resident #3 and asked the resident where she usually gets the gel. Resident #3 stated she did not know the answer to LVN A's question. Resident #3 added she did not have pain anywhere at that moment. LVN A held the medication. Resident #36Record review of Resident #36's undated admission record revealed a [AGE] year-old male with an admission on [DATE]. Resident #36 had diagnoses including contusion (tissue injury caused by a blunt impact) of lower back and pelvis. Record review of Resident #36's Care Plan initiated on 03/18/2026 read, resident had pain in both knees. The interventions read, apply diclofenac gel to both knees topically four times a day for pain. Record review of Resident #36's admission MDS dated [DATE] revealed a BIMS score of 15 meaning the resident was cognitively intact. Record review of Resident #36's Physician Orders, dated 03/12/2026, revealed the following:-An active order of diclofenac gel 1%. Apply to affected area topically four times a day for pain. The order did not specify where to apply the gel over.-An active order of polyethylene glycol 3350 oral powder 17 gm/scoop. Give 1 scoop by mouth daily for constipation. The order did not specify how much fluid to mix the powder with. During an observation on 03/18/2026 at 9:18 a.m., LVN A poured and mixed polyethylene glycol powder with (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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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	an unmeasured amount of water and gave it to Resident #36. Further observation revealed LVN A prepared Voltaren gel and went to Resident #36 and asked the resident where he usually gets the gel. Resident #36 stated he was not aware where he should have received the gel over. LVN applied the Voltaren gel on the resident's leg near a lidocaine pain patch that staff applied earlier. In an interview on 03/18/2026 at 9:20 a.m., LVN A stated she should have held both residents' medication administration and contacted the provider for clarification on those orders. LVN A stated she checked orders for instructions on how to administer medications. She stated she did not follow the proper procedure this time. LVN A stated all orders were incomplete and that could cause Residents #3 and #36 to receive medications that were ineffective. Resident #20Record review of Resident #20's undated admission record revealed a [AGE] year-old male with an admission on [DATE]. Resident #20 had diagnoses including multiple fractures (broken bones) of left femur, dementia (decline in mental ability), constipation and cognitive communication deficit (difficulty with communication). Record review of Resident #20's Care Plan initiated on 11/01/2022 and last revised on 03/09/2026 read, resident had a diagnosis of constipation. The interventions read, monitor side effects of constipation and record bowel movement pattern each day. Record review of Resident #20's Quarterly MDS dated [DATE], revealed a BIMS score of 6 with severe cognitive impairment, meaning the resident had significant memory, orientation, or decision-making challenges, often required extensive assistance with daily activities. Record review of Resident #20's Physician Orders, dated 02/16/2026, revealed an active order of diclofenac gel 1%. Apply to affected area topically four times a day for pain. The order did not specify where to apply the gel over. Record review of Resident #20's Physician Orders, dated 05/13/2022, revealed an active order of polyethylene glycol 3350 oral powder 17 gm/scoop. Give 1 scoop by mouth daily for constipation. The order did not specify how much fluid to mix the powder with. During an observation on 03/18/2026 at 8:18 a.m., LVN B poured and mixed polyethylene glycol powder with an unmeasured amount of water and gave it to Resident #20. LVN B stated she should have held the medication administration and contacted the provider for order clarification. LVN B stated she checked orders for instructions on how to administer medications. She stated she did not follow the proper procedure this time. LVN B stated the medication order was incomplete and that could cause Resident #20 to receive a medication that was ineffective. In an interview on 03/18/2026 at 10:05 a.m., the MD stated polyethylene glycol orders should have included between 4 and 8 oz. of fluids to mix the powder with, and the Voltaren gel orders should have included the application area where the gel was indicated to treat. The MD stated she expected the prescribing provider, who was not available to interview, to include the amount of fluid in those orders and the application area or body parts. The MD stated she expected nurses to contact the provider for clarification about medication orders when those orders missed instructions on how to use them. She stated mixing the MiraLAX powder with fluids without specifying the amount could not cause significant harm. She stated those orders were incomplete and required medication verifications. The MD stated she reviewed residents' orders, including medications, every week. In an interview on 03/18/2026 at 10:28 a.m., the DON stated he expected Nurses to call the provider to request medication verifications on all incomplete orders when those orders missed instructions on how to administer them. She stated nurses should have sought clarification about the amount of water required to mix the powder with before each administration and verified where Voltaren gel should have been applied. The DON stated using the wrong amount of water to mix the powder could prevent the medication from working as prescribed and could cause fluid overload for residents with fluid restrictions. The DON stated not knowing where to apply the Voltaren gen could cause residents' pain to be left untreated. She stated she performed review on residents' medication orders every day during the morning clinical meetings. She stated all those incomplete orders must have been missed during the review. The DON added she performed random daily audits on medication passes. Record review of Miralax manufacturer's recommendations dated 2026, revealed, .Take 17 gram of powder once a day. Use the Miralax bottle top to measure 17gram by filling to the indicated line (white section (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	in cap). Mix and dissolve into 4-8 ounces of any beverage (hot, cold or room temperature). Record review of the facility's Medication and Treatment orders Policy dated February 2014, revealed, .9. Orders for medications must include.e. clinical condition or symptoms for which the medication is prescribed. The policy did not mention medication orders for locally applied medications or instructed staff to follow manufacturers' recommendations to guide medication administration.