STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425326	A. Building B. Wing	06/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hallmark Healthcare Center	255 Midland Parkway Summerville, SC 29485

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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 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** 47075 Based on review of the facility policy, observation, record review, and interview, the facility failed to ensure that 1 (Resident (R)17) of 5 residents observed for resident rights was provided bathing preferences. Findings include: Review of the facility's policy titled, Social Services Policies and Procedures with a complete revision date of 10/01/20, revealed, The Facility provides care for each resident in a manner that promotes, maintains, or enhances quality of life, recognizing each resident's individuality. Review of R17's Admission Record revealed R17 was admitted to the facility on [DATE], with diagnoses including but not limited to; Parkinson's disease, multiple sclerosis, type 2 diabetes mellitus without complications, and major depressive disorder. Review of R17's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/18/23, revealed R17 had a Brief Interview for Mental Status (BIMS) score of 11 out of 15, indicating R17 was moderately cognitively impaired. Further review of the MDS revealed, it is somewhat important for R17 to have a shower over a bed bath. Review of the Shower Records revealed that R17 was scheduled for showers on Mondays and Thursdays, on second shift. A complete review of the shower sheets revealed no evidence that R17 had received a shower over the period of 02/26/23 to 06/21/23. During an observation on 06/20/23 at approximately 12:37 PM, R17 was observed in her room, in the bed which was in an elevated position. R17's hair was greasy and unwashed and she was wearing a night grown. During an interview with R17 on 06/20/23 at approximately 12:39 PM, she stated that she prefers showers, her shower days are Monday and Thursday. R17 further stated, she has not had a shower since February 2023. R17 stated staff will say she refuses showers, but she does not refuse. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/23/23 at approximately 1:11 PM with Certified Nursing Assistant (CNA)1, revealed that CNA1 provides Activities of Daily (ADL) services to R17. CNA1 revealed she usually provides R17 with complete bed baths or partial bed baths. CNA1 stated that R17's shower days are Mondays and Thursdays. CNA1 concluded that R17 has not requested showers. During an interview with the Activity Director (AD), on 06/23/2023 at 11:12 AM, the AD revealed that residents are provided with an activity calendar and activity staff go to the resident rooms and ask if residents would like to attend activities. The AD stated participation is very low at this facility, some of it's due to residents not wanting to participate and some is due to staff not getting residents out of bed. R17 has expressed to the AD that she would like to come to activities and has stated that staff will not get her up for showers or activities.

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46991 Based on review of facility policy, record reviews, and interviews the facility failed to provide a notice of transfer for hospitalization and the reasons for the transfer in writing or as soon as practicable to Resident (R)59 and R26, the Resident Representative and Ombudsman for 2 out of 2 residents. Findings include: Review of the facility's policy titled, Social Services Policies and Procedures Discharge Notification with a complete revision date of 10/01/20 documented under section Discharge Notification. The Social Services Staff/or designee is charged with ensuring that systems are in place to provide written notification to the patient/resident and if known, a family member or legal representative prior to the patient's/resident's transfer and the LTC ombudsman. The notifications must be documented in the resident's medical record. The transfer/discharge notice must comply with federal and state regulations and must contain the following information. The facility policy further reveals #6. Notice before transfer (a) Before a facility transfer or discharges a resident, the facility must (1) notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. (2) The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman and documentation to reflect in the resident's medical record. (3) Document the reasons for the transfer or discharge in the resident's medical record as noted above in Page 7 (3) A 2. 1. Review of R59's Face Sheet revealed R59 was admitted to the facility on [DATE]. Review of R59's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 04/30/23 revealed a Brief Interview of Mental Status (BIMS) score of 0 out of 15, indicating R59 was severely cognitively impaired. Review of R59's Progress Note dated 03/21/23 at 2:29 PM (recorded as late entry on 03/21/2023 at 5:56 PM) revealed, .PER wound care NP resident to be transferred to [local hospital] for eval and TX. Review of R59's Progress Note dated 04/17/23 at an unspecified time revealed, Resident returned at 4pm via stretcher . An interview with the Administrator on 06/22/23 at 3:37 PM, revealed the facility doesn't have documentation in writing of notification of the reason for the transfer/discharge, to the hospital, in a language they understand, nor a copy of the notice sent to the Ombudsman office. A follow up interview with the Administrator on 06/22/23 at 3:53 PM, revealed the Administrator presented the surveyor with the Admission Handbook, which included the Behold Policy basic per diem rate of $194.50. The Administrator stated, this is presented to residents at admission and reviewed during admission meeting with the bed hold rate. The Administrator stated this is not provided at the time of transfer/discharge. The Administrator further stated, they mail the names of residents who were transferred or discharged to the Ombudsman Office. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Ombudsman's Office on 06/23/23 at 9:16 AM revealed, the Ombudsman didn't receive any discharge information regarding R59. The Ombudsman stated normally the facility will notify the office through email or fax. An interview with Social Services (SS) on 06/23/23 at 2:02 PM revealed, SS stated for residents discharged and/or transferred she completes the forms and place the forms in Matrix. The SS stated she is unsure of what the policy is. She stated she will notify the Ombudsman by email. The SS stated she does not document this process anywhere, except to place the documents on Matrix. 2. Review of R26's Face Sheet revealed R26 was admitted to the facility on [DATE], with the latest return on 11/21/22. R26 was admitted with diagnoses including, but not limited to; osteomyelitis of vertebra, sacral and sacrococcygeal region, acute tracheitis, peripheral vascular disease, type 2 diabetes mellitus, and pressure ulcer of sacral region, stage 4. Review of R26's Progress Note dated 03/27/23 at 6:51 PM, revealed, 635p alerted by daughter feeding was coming out at connection of peg tube, requested by daughter to have her sent out via 911 to [local hospital]. RN at [hospice] made aware. DON also informed. Review of R26's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/19/23 revealed R26 did not have a Brief Interview for Mental Status (BIMS) conducted, as the resident is severely cognitively impaired. Review of R26's electronic medical record, revealed that R26 was discharged to the hospital on 03/27/23 and no documentation detailed that there had been any correspondence to notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move, verbally or in writing, in a language and manner they understand. An interview on 06/23/23 at 10:29 AM with the Director of Nursing (DON), revealed that R26 had issues with her feeding tube, and it kept coming out, the facility put it back in, but the daughter of R26 wanted it reevaluated to make sure they had completed the procedure correctly, so they sent her to the emergency room (ER). The DON revealed that each time she goes out she is provided with discharge and bed hold information, that is usually provided by the business office and social worker, but she was not able to present documentation that was provided to R26 at this time. 47257

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46991 Based on review of facility policy, record review, and interviews, the facility failed to provide 2 out of 2 residents a copy of the bed hold policy in order to ensure that Resident (R)59 and R26 were aware of the bed hold policy and basic per diem rate. Findings include: Review of the facility's policy titled, Facility's Policy and State Requirements for a Temporary Leave Bed-Hold dated (Admissions Handbook) revised 03/2023 documented, the resident and/or his/her representative will be given a copy of the Facility's bed-hold policy before the resident actually leaves for his/her temporary leave or hospitalization , the bed hold policy may accompany the resident to the hospital or will be given to the resident or his/her legal representative within twenty-four hours of the resident's hospitalization . Review of R59's Face Sheet revealed R59 was admitted to the facility on [DATE]. Review of R59's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/30/23 revealed, R59 had a Brief Interview for Mental Status (BIMS) score of 00 out of 15, indicating R59 had severe cognitive impairment. Review of R59's Progress Note dated 03/21/23 at 2:29 PM (recorded as late entry on 03/21/2023 at 5:56PM) revealed, . PER wound care NP resident to be transferred to [Local hospital] for eval and TX. Review of R59's Progress Note dated 04/17/23 revealed, Resident returned at 4pm via stretcher. In an interview with the Administrator on 06/22/23 at 3:37 PM, revealed the facility doesn't have documentation in writing of notification of the reason for the transfer/discharge to the hospital in a language they understand nor a copy of the notice sent to the Ombudsman office. In a follow up interview with the Administrator on 06/22/23 at 3:53 PM revealed, she presented the surveyor with the Admission Handbook with the Behold Policy basic per diem rate of $194.50. The Administrator stated this is presented to the resident at admission and reviewed during admission meeting with the bed hold rate. She stated this is not provided at the time of transfer/discharge. She further stated they mail the names of residents transferred or discharged to the Ombudsman Office. In an interview with the Ombudsman Office on 06/23/23 at 9:16 AM, revealed the Ombudsman did not receive any discharge information for R59 for the month of March 2023. She stated normally the facility will notify the office through email or fax. In an interview with Social Services (SS) on 06/23/23 at 2:02 PM, revealed for residents discharged and/or transferred SS would complete the forms and place the forms in Matrix. She stated she is unsure of what the policy is. She stated she will notify the Ombudsman by email. She stated she does not document this process anywhere, except to place the documents on Matrix. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of R26's Face Sheet revealed she was admitted to the facility on [DATE], with the latest return on 11/21/22. Review of R26's Progress Note dated 03/27/23 at 6:51 PM, revealed 635p alerted by daughter feeding was coming out at connection of peg tube, requested by daughter to have her sent out via 911 to [local hospital]. RN at [Hospice] made aware. DON also informed. Review of R26's Quarterly MDS with an ARD of 05/19/23, revealed R26 did not have a BIMS assessment conducted, as the resident is severely cognitively impaired. Review of R26's Electronic Medical Record (EMR), revealed that she was discharged to the hospital on 03/27/23. Further review of the EMR, revealed no documentation that any correspondence to notify the resident and the resident's representative(s) of the bed hold policy, as it is required that facilities provide written information about the policies prior to and upon transfer for such absences. The notice must be provided to the resident, and if applicable the resident's representative, at the time of transfer and include the reserve bed payment policy. An interview on 06/23/23 at 10:29 AM with the Director of Nursing (DON), revealed that R26 had issues with her feeding tube, and it kept coming out, the facility put it back in, but the daughter of R26 wanted it reevaluated to make sure they had completed the procedure correctly, so they sent her to the emergency room (ER). The DON revealed that each time she [R26] goes out she is provided with discharge and bed hold information, that is usually provided by the business office and social worker, but she was not able to present documentation showing that was provided to R26 or R26's representative at this time. 47257

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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. 48447 Based on observations, interviews, record review, and facility policy review, the facility failed to develop a comprehensive person-centered care plan for 1 (Resident (R)60) of 5 residents whose comprehensive care plans were reviewed. Specifically, the facility failed to develop a comprehensive care plan for R60 to be on isolation precautions for the diagnosis of sabies. Findings include: Review of the facility policy titled, Care Plan Process, Person-Centered Care with an effective date of 05/05/23, revealed .the baseline person-centered care plan will include the minimum healthcare information necessary to properly care for the resident including, but not limited to initial goals based on admission orders, resident goals, physician orders, dietary orders, therapy services, social services, and PASARR recommendation, if applicable. Review of R60's Resident Face Sheet indicated the facility admitted (R)60 on 03/10/23 with diagnoses that included but was not limited to; Parkinson's disease, psoriasis, dementia, anxiety disorder, and psychotic disorder with delusions due to known physiological condition. Review of R60's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/16/23, revealed (R)60 had a Staff Assessment for Mental Status (SAMS) that indicated the resident had moderately impaired cognitive skills for daily decision making and had short and long-term memory problems. The MDS indicated the resident did not have any skin condition but was receiving applications of ointments. The MDS indicated the resident was independent with transfers, eating, toileting, personal hygiene and bed mobility. Review of a Care Plan(s), Review of a Care Plan, with a problem start date of 06/20/2023, revealed Resident #60 had a rash on the residents back.The facility developed interventions that included to administer medications as ordered, discourage resident from scratching area to reduce tissue damage, monitor and record complaints of pain/itching/discomfort, and to conduct a systematic skin inspection per doctor's orders. Care plan did not identify scabies prior to 6/20/23. Review of History and Physical indicated the date of service was 03/14/2023 and the resident had a past medical history of psoriasis. Review of Focused Observation, completed on 03/17/2023 at 7:16 PM indicated the resident had warm, dry skin with normal color and turgor with no alterations in skin. Review of Focused Observation, completed on 06/09/2023 at 11:46 AM indicated the resident had cool, extremely dry skin with normal skin turgor. The observation also included an additional comment of psoriasis. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Focused Observation, completed on 06/16/2023 at 12:42 AM indicated the resident had warm, dry skin of normal color and normal skin turgor. The observation included the resident had alterations in skin that included redness to arms, legs, trunk and face and the resident had creams ordered for treatment. Review of Resident Progress Notes revealed on 06/14/2023 at 12:58 PM, Licensed Practical Nurse (LPN)6 documented R60 received a new physician's order for Permethrin cream and Ivermectin treatment due to a new diagnosis of scabies. The resident was reminded to stay in their room and use the call bell for assistance and contact precautions were in place. Review of Order History was reviewed from 05/21/2023 through 06/21/2023 and revealed on 06/14/2023, there was a one-time physician's order for permethrin 5% topical cream to be applied to the resident's entire body and to leave on for eight to 12 hours and wash off. The same order was repeated on 06/20/2023. There was no physician's order listed for the resident to be on contact isolation. During a concurrent observation and interview on 06/20/2023 at 1:33 PM, Resident #60 walked down the hallway of Zone 3, past the nurse's station and entered the Day Room to speak to the surveyor using an interpreter on an iPad. The interpreter had a difficult time understanding the resident, but the resident indicated the she had itching but did not specify where. She indicated to the interpreter that the facility had applied a cream but that did not help with the itching. During the interview, the resident was observed scratching both arms. During an observation on 06/20/2023 at 3:51 PM, R60 was observed walking down the hall designated as Zone 3 using their walker for assistance. At 3:54 PM, the resident was observed walking back down the hallway. During an observation on 06/20/2023 at 4:09 PM, R60 was sitting on their rolling walker in the hallway of Zone 3. During an interview on 06/23/2023 at 11:40 am, the MDS Coordinator stated she was responsible for updating care plans. She stated if a resident is on contact isolation, there should be a care plan addressing it. While reviewing R60's care plan, the MDS Coordinator indicated the care plan should have been updated on 06/14, but she is running behind due to staffing shortages. During an interview on 06/23/2023 at 11:59 AM, the Director of Nursing (DON) reported the MDS Coordinator is responsible for care plan updates. She stated if a resident is on any type of tranmission based precautions, their care plan should be updated. During an interview on 06/23/2023 at 12:05 PM, the Corporate Clinical Director stated she was made aware that R60 did not have an accurate care plan and her expectations was that staff would update the care plan accurately.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47075 Based on review of facility policy, observation, record review, and interview, the facility failed to ensure that 1 (Resident (R)17) of 5 residents reviewed for activities received activities that meet the intent and needs of each resident. Findings include: Review of the facility's policy titled, Activity Policies and Procedures with a complete revision date of 09/01/20, revealed, The Activity/Recreational Director and staff will schedule programs and events at times available to patients and resident interests, hobbies, and cultural preferences. Review of R17's Admission Record revealed R17 was admitted to the facility on [DATE], with diagnoses including but not limited to, Parkinson's disease, multiple sclerosis, type 2 diabetes mellitus without complications, and major depressive disorder. Review of R17's annual Minimum Data Set (MDS), located in the Electronic Medical Record (EMR) under the MDS tab, with an Assessment Reference Date (ARD) of 02/18/23, revealed R17 had a Brief Interview for Mental Status (BIMS) score of 11 out of 15, indicating R17 was moderately cognitively impaired. Further review of the MDS revealed it is somewhat important for R17 to have their favorite activities. During an observation on 06/20/23 at approximately 12:37 PM, R17 was observed in her room, in the bed with the head of bed in an elevated position. An interview with R17 on 06/20/23 at approximately 12:39 PM, revealed R17 is interested in attending activities and she never gets to attend any activities. R17 stated that staff come around informing her of activities, but staff never take her to any of the activities and she does not refuse to attend activities. An interview with the Activity Director (AD) on 06/23/2023 at 11:12 AM, revealed residents are provided with an activity calendar and activity staff go to the resident rooms and ask if residents would like to attend activities. The AD stated resident participation is very low at this facility, some of it's due to residents not wanting to participate and some is due to staff not getting residents out of bed. R17 has expressed to the AD that she would like to come to activities and has stated that staff will not get her up for activities. During an interview on 06/23/23 at approximately 12:37 PM with the Director of Nursing (DON), she revealed we ensure staff are available to assist with activities in and out of the facility. The DON stated she was not aware that R17 wanted to attend activities.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 48447 Based on review of facility policy, observation, record review, and interview, the facility failed to ensure Resident (R)55 was free from significant medication errors related to blood pressure (BP) medication administration for 1 of 5 residents reviewed for medication administration. Findings include: Review of the facility's policy titled, Medication Management Program with a complete revision date of 05/05/23 revealed, Prior to administering medications, the nurse is responsible for A. Obtaining and recording any necessary vital signs. A review of R55's electronic medical record (EMR) revealed R55 was admitted to the facility with diagnoses that included but was not limited to; Wernicke's encephalopathy, major depressive disorder, bradycardia, and hypertension. Review of R55's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/03/23, revealed a Brief Interview for Mental Status (BIMS) score of 7 out of 15, which indicated the resident was severely cognitively impaired. A review of R55's care plan, revised on 02/23/2022, revealed the following: has cardiac disease with diagnoses of Hypertension, Bradycardia, Iron-deficiency anemia, and is being treated as ordered. Interventions include to administer meds as ordered per physician's orders, check Medication Administration Records (MARs) for current dose/time, Monitor for cardiac distress and update physician as needed. Also, monitor ordered labs, vital signs. Administer diet as per physician orders and monitor for weight gain, shortness of breath, edema and update physician with any changes. Monitor for cardiac BP variances, sudden weakness or pallor, shortness of breath, distress, (i.e.) chest pain, dizziness, changes in vital signs and update MD as needed. Monitor/document/report as needed abnormal laboratory values (e.g., white blood cell count and differential, serum protein, serum albumin, and cultures). A review of R55's June 2023 physician's orders revealed an order for Chlorthalidone tablet 25 milligrams (mg)- one half tablet with special instructions to hold if the systolic blood pressure was less than 100. During an observation and interview on 06/23/23 at 9:23 AM, Licensed Practical Nurse (LPN)1 was observed completing the morning administration of medication to residents. LPN1 stated that R55 had an order for Chlorthalidone tablet 25 mg, one half tablet, Loratadine 10 mg 1 tablet, and Thiamine mononitrate (vitamin B1)- 1 tablet. R55 was observed lying in bed with the head of bed elevated. LPN1 administered the Chlorthalidone 25 mg, one half tablet to the resident without checking R55's blood pressure. During an observation on 06/23/23 at 10:10 AM, LPN1 checked R55's blood pressure. The first BP was 98/61 with R55 lying down. The second check was 81/64 in the left arm. The third check, manually was 114/65. LPN1 then asked R55 how he felt and he stated he felt tired. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LPN1 on 06/23/23 at 10:20 AM, she stated she administered the medication based on R55's BP from the previous day. She revealed that she should have taken a fresh BP. She added that by administering the medication without checking the BP, there could have been adverse reactions to R55. During an interview with the Director of Nursing (DON) on 06/23/23 at 11:59 AM, she stated her expectation was for staff to follow the parameters of the orders. If the medication was to be held, it should have been. She stated that vital signs should not be used from the previous day to administer medications.

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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 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** 47257 Based on observations, interviews, and review of the facility policy, the facility failed to ensure foods that are stored in the freezer, dry storage, emergency storage and resident dietary rooms were properly labeled and discarded after the manufacturer's expiration date. Findings Include: Review of the facility's policy titled, Food Safety in Receiving and Storage, dated [DATE], revealed, Food will be received and stored by methods to minimize contamination and bacterial growth. Receiving Guidelines .6. Check expiration dates and use-by dates to assure the dates are within acceptable parameters. Dry Storage Guidelines .3. Containers holding food or food ingredients that are removed from their original packages such as cooking oils, flour, sugar, herbs and spices are identified with he common name of the food. Refrigerated Storage Guidelines .12. Refrigerated, ready to eat Time/Temperature Control for Safety Foods (TCS) are properly covered, labeled, dated with use-by date, and refrigerated immediately. [NAME] them clearly to indicate the date by which the food shall be consumed or discarded. During an observation on [DATE] at 11:14 AM of the kitchen, walk-in refrigerator, dry food storage area, walk-in freezer, and emergency storage room revealed the following: Kitchen: A large bin of powder like substance that was not labeled or dated. The substance was confirmed to be flour by the Kitchen Manager (KM). Walk-in Refrigerator: A box of Idaho potatoes, contained one potato that had a mold-like substance on the skin. Dry Food Storage Area: Three packs of 6' Flour Tortillas with an expiration date of [DATE] and a received date of ,d+[DATE]. Walk-in freezer: A clear container labeled as corn and tomatoes, had a use by date of [DATE]. A large square clear container containing a red substance was not labeled or dated; the KM stated that was spaghetti sauce. The emergency storage room contained a large box of Zesta box crackers with an expiration date of , d+[DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425326	A. Building B. Wing	06/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hallmark Healthcare Center	255 Midland Parkway Summerville, SC 29485

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	All items identified above were removed by the KM. During an observation on [DATE] at 2:03 PM of the 200-hall resident dietary room, revealed a large clear plastic Ziplock bag that contained 22 individually wrapped Kellogg Honey [NAME] crackers and two Zesta Saltines, which were not dated. During an interview on [DATE] at 11:20 AM, with the KM, revealed that all items should be labeled with the date the product was opened and a use by or expiration date. The items are checked about every other day, to keep an accurate record of what can be used or what needs to be thrown out. She includes they must do a better job looking at the dates when they receive the items because some of them are already expired when they get them from the food provider. The KM includes she is fairly new and her expectation is for all staff to follow policies to ensure that there aren't any deficiencies in the kitchen. During an interview on [DATE] at approximately 12:00 PM with the Administrator, revealed they had just cleaned out their emergency supply room and that box must have been overlooked. The maintenance director removed the box from the room. During a follow up interview on [DATE] at 2:10 PM the KM, revealed that they usually write down the day they bring the snacks down to the dietary rooms and the date is placed on the Ziploc bag. They typically replace the snacks every three days, and they provide them to the halls as requested by the nurses.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 47257 Based on record review, interviews, and facility policy review, the facility failed to implement procedures and safeguards to reduce the potential growth and spread of Legionella. This failure had the potential to affect all resident in the facility. Findings include: A review of the facility's policy titled, Water Systems, Safety and Management, with a complete revision date of May 15,2023, revealed, Facility will implement procedures and safeguards to reduce the potential of growth and spread of Legionella and other opportunistic pathogens in building water systems. 1. A. Using this policy and the Centers for Disease Prevention and Control's Facility Leadership will assess water systems. B. Facility Leadership in conjunction with the Safety Committee and Infection Preventionist will comprise the Water Management Team. This team is overseen and facilitated by the Administrator to ensure adequate resources and Program Implementation. During an interview with the Maintenance Director (MD) on 06/23/23 at 1:52 PM, revealed that no water management program to prevent the growth of Legionella was established and that the Commissioners of Public Works (CPW) came and tested the water, but they informed him that he needed to contact a private company to come out and test the water for Legionella. The MD stated that they have not had any cases in the building, and he recognizes the symptoms of the disease include nausea and vomiting. The MD further stated that the facility does not have any water fountains, they use five-gallon water bottles to provide water to the residents. During an interview with the Infection Preventionist (IP) on 06/23/23 at 2:06 PM, the IP stated that maintenance was over the water management program and that was, beyond her duties.