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	05/01/2026

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

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 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. Based on observation, record review and staff interview, the facility failed to provide sanitary meal service when two kitchen staff failed to don [put on] appropriate facial hair covers for food preparation. This failure had the potential to affect 79 residents receiving dietary services from the facility. Findings include:Review of the facility policy Nutrition Policies and Procedures dated 10/15/25 revealed, POLICY: The Dietary Department employees will adhere to a facility dress code that facilitates safe and sanitary meal production and service .6. Appropriate hair restraints (hair covers or nets, beard restraints) while involved in food production activities . On 04/29/26 from 5:49 AM through approximately 6:20 AM, a brief tour of the kitchen was conducted. Upon entry to the kitchen, [NAME] (DD) and Dietary Aide (FF) were observed preparing breakfast. Both staff had facial hair/beards. They were wearing head covers but had not donned facial hair covers prior to the surveyor donning a hair net and asking staff if facial hair covers were available for them to use to cover their facial hair while preparing food for the residents. Each donned facial hair covers at that time. During an interview with the Dietary Manager (DM), on 05/02/26 at 8:30 AM he confirmed that a facial hair covering was required while preparing food for the residents.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on record review and interview, the facility failed to act promptly and to provide documented responses to recurring grievances related to call light response times that were expressed during resident council meetings for 10 of 13 months of meeting minutes reviewed. (June 2025, July 2025, August 2025, September 2025, October 2025, November 2025, December 2025, January 2026, February 2026, and March 2026) Findings include:A review of the undated facility policy titled, Social Services Policies and Procedures, with a revision date of 11/06/23, revealed, Subject: Complaints/Grievances process. Policy: . 2. Facility Leadership acts promptly to understand and resolve complaints and grievances completed in a reasonable expected time frame . Responsibility of Grievance Official: Identifying a Grievance Official who is appointed by the Administrator and who is responsible for: 1. Overseeing the grievance process, receiving, and tracking grievances through to their conclusions . 5. As necessary, taking immediate action to prevent further potential violations . Grievance Reports: . C. The Quality Assurance and Performance Improvement Committee (QAPI) discusses trends and patterns to identify areas of opportunity for resolution and prevention of recurrence . A review of the resident council meeting monthly minutes including April 2025 through April 2026 revealed the topic of resident call light response time complaints each month from June 2025 through March 2026, a total of 10 months without resolution documented on the meeting minutes. An interview with Resident (R)12 on 04/30/26 at 9:00 AM revealed he has had a concern with call light response times for a long time. During the group interview held on 04/30/26 at 2:00 PM, R12 identified a concern related to call light response times and stated, They occasionally take a long time to answer them, and that is usually at night. An interview with the Activities Director (AD) CC on 05/01/26 at 9:00 AM revealed that she documented complaints and/or grievances brought up at the resident council meeting and reported them to social services. Except for December 2025, AD CC did not know why the concerns with call light response times documented on the resident council meeting minutes between June 2025 and March 2026 were not included on the grievance log which is maintained by Social Services (SS) DD who is the grievance coordinator.An interview with SS DD on 05/01/26 at 9:15 AM revealed she is the grievance coordinator. Depending on the complaint, she delegates or refers them to the department most appropriate to handle the complaint. Call light complaints are referred to nursing, specifically the Director of Nursing (DON) for investigation and resolution. She reviewed the resident council minutes and the grievance logs for the last 13 months and confirmed there were two call light grievances which had been documented as resolved on the grievance log, and there were 10 months wherein call light concerns were documented on the resident council minutes. She also confirmed that the call light grievance dated 12/11/25 coincided with the resident council meeting minutes dated the same. She agreed that call light concerns, whether in resident council meeting or as an individual grievance should be responded to in a timely manner. She agreed that 10 months was not in a timely manner. She further stated that she did not know the reason the grievances documented on the resident council meeting minutes were not documented on the grievance and stated that they probably should have been.In an interview with the Director of Nursing (DON) on 05/01/26 at 9:20 AM, she confirmed that she, along with the Administrator, responded to call light grievances reported to them by SS DD. She confirmed that there were two call light grievances which had been documented as resolved on the grievance log, and there were 10 months wherein call light concerns were documented on the resident council minutes. She also confirmed that the call light grievance dated 12/11/25 coincided with the resident council meeting minutes dated the same, and that all call light concerns should be on the grievance log. She agreed that call light concerns should be responded to in a timely manner. She agreed that 10 months was not in a timely manner.