STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425326	A. BUILDING _____ B. WING _____	**07/28/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0604 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon observations, interview, record review, and review of facility policy, the facility failed to ensure that one (1) of one sampled residents reviewed for physical restraints (Resident #1) was free of physical restraint use implemented for staff convenience. Resident #1 was physically restrained by Certified Nursing Assistant (CNA) #1 on 7/18/2020 causing harm to Resident #1. Resident #1 was restrained in bed to prevent her/him from moving; a sheet was tied tightly across the resident's body with the four corners of the sheet affixed to the bed frame. When the resident was found by a nurse, s/he had experienced psychosocial and physical harm including indentations in her legs from the pressure of the sheet. Findings include: Review of Resident #1's Face Sheet dated 7/27/2020 reflected [DIAGNOSES REDACTED]. During an observation of Resident #1 in her room on 7/27/2020 at 3:50 p.m. the resident was agitated and was asking for assistance. Resident #1 was covered by a sheet and did not appear to be wearing any bedclothes. Resident #1 was not interviewable. Review of Resident #1's Annual Minimum Data Set ((MDS) dated [DATE] reflected a Brief Interview for Mental Status (BIMS) score of five (5) indicating severe cognitive deficit. The MDS reflected the requirement for extensive assistance with activities of daily living (ADLs) and that Resident #1 was incontinent of bowel and bladder. The MDS reflected that Resident #1 exhibited mood and behavior issues during the reporting review period. Resident #1"s Personal Health Questionnaire-9 (PHQ-9) reflected a score of twelve (12) indicating moderate depression as evidenced by almost daily symptoms of depression, sleep disturbance, difficulty concentrating, and fatigue. Review of Resident #1's current [MEDICAL CONDITION] medication orders reflected Memantine [MEDICATION NAME] Extended Release (dementia medication) 28 mg once a day for dementia, [MEDICATION NAME] (anti-anxiety medication) 10 mg twice a day for depression, [MEDICATION NAME] (anti-[MEDICAL CONDITION] and benzodiazepine) 1 mg each morning and 2 mg each night for anxiety, Nudexta (medication for pseudobulbar) at unknown dosage twice a day for pseudobulbar affect, and Donepezil (dementia medication) 10 mg each night for dementia. Review of Resident #1's care plan dated 7/7/2020 reflected plans for behavior, [MEDICAL CONDITIONS], mood, depression, falls, communication, impaired skin integrity, bowel and bladder incontinence, pain, anxiety, and ADLs with interventions including anticipating and meeting the resident's needs in a timely manner, maintaining a calm and supportive environment, medication per physician's orders [REDACTED]. Review of Resident #1's care plan dated 7/28/2020 reflected that the care plan had not been updated following the incident of 7/18/2020. Review of the facility's 5-Day Follow Up Report dated 7/23/2020 reflected that Licensed Professional Nurse (LPN) #1 found Resident #1 restrained in his/her bed with a bed sheet on 7/18/2020 at 5:40 p.m. Resident #1 had a bed sheet tied tightly across his/her body from just below the breast area to just above the knees. The four (4) corners of the bed sheet were knotted to the bed frame, and Resident #1 was unable to move in his/her bed. LPN #1 took immediate action to release Resident #1 and performed an assessment of Resident #1 that documented indentations in the resident's lower extremities with noted [MEDICAL CONDITION] and no other injuries. The report of alleged abuse was filed with the State of South Carolina DHEC by phone within two (2) hours according to the report notes, and by fax on 7/20/2020. The investigation was instituted by the facility and completed on 7/23/2020 with a finding of substantiated physical abuse by CNA #1. Review of the Nursing Notes reflected no psychosocial assessments following the incident on 7/18/20. Review of the Social Services notes reflected that the SW had facilitated a Facetime visit between Resident #1 and the RP but had no other entries of psychosocial assessment. The facility had statements from LPN #1 and LPN #2 that CNA #1 had told them that s/he had tied Resident #1 down with a bed sheet because Resident #1 had removed his/her brief three (3) times that day and that CNA #1 didn't want to have to keep changing Resident #1's brief, and the sheet would keep Resident#1 from being able to remove his/her brief. Review of the facility Abuse, Neglect, Exploitation, or Mistreatment Policies and Procedures dated 11/1/2017 reflected that the facility prohibited use of a physical and/or chemical restraint not required to treat a medical condition. The policy defined physical restraint use (not required to treat a medical condition) as physical assault/abuse. The policy further reflected that mistreatment meant inappropriate treatment of [REDACTED].#1 was provided to the facility by a staffing agency. The Administrator stated it was the facility's responsibility to ensure that residents were free of physical restraints. The Administrator stated the Director of Nursing (DON) conducted and completed the investigation of the incident of 7/18/2020 involving physical restraint of Resident #1. During an interview on 7/28/2020 at 8:00 a.m. Resident #1's Responsible Party (RP) RP stated that s/he was aware of the incident on 7/18/2020. The RP stated that the incident was particularly unfortunate because Resident #1 had suffered significant spousal physical and emotional abuse which was the cause of her/his [MEDICAL CONDITION], and that an incident of this type could cause increased anxiety for Resident #1. During an interview on 7/28/2020 at 2:49 p.m. the Social Worker stated s/he normally followed up on this type of incident by interviewing residents for safety concerns but did not do so in this case because the Administrator and DON conducted the investigation. S/he stated that s/he checked on Resident #1 after the incident and had arranged for a Peacetime visit between Resident #1 and the RP on 7/23/2020. Review of Resident Progress Notes dated 7/23/2020 at 12:02 p.m., recorded by the SW, reflected that a face time call had been held with Resident #1 and the RP with the assistance of the facility Activity Staff. During an interview on 7/28/2020 at 2:24 p.m. the Physician's Assistant (PA) PA stated that s/he was told about the incident on 7/19/2020 in the morning when s/he came in to do rounds. S/he stated that s/he examined Resident #1 on 7/19/2020 and found no trauma but noted that Resident #1 continued to exhibit significant anxiety. S/he stated that s/he did not document the examination of 7/19/2020. S/he said his/her focus on Resident #1 was on the resident's anxiety and that s/he had been trying to medically manage the anxiety and had increased anti-anxiety medications ([MEDICATION NAME]) from 0.5 mg twice a day to 1.0 mg twice a day on 7/20/2020 due to increased anxiety with elevated blood pressure. S/he stated that s/he was planning to place a referral for a repeat psychiatric evaluation of Resident #1 due to Resident #1's anxiety but had not done so yet. During an interview on 7/28/2020 at 3:51 p.m. LPN #1 stated that s/he was the nurse who discovered Resident #1 restrained in bed. LPN #1 said Resident #1 was not on her assignment that evening but the staff CNA came to her for help because s/he was the only non-agency nurse on duty. LPN #1 stated the nurse who was taking care of the resident was LPN #2 who was either agency or PRN (as-needed staff) and that LPN #2 didn't know what had happened when the incident was discovered. LPN #1 stated that one (1) of the staff CNAs frantically asked her to come see Resident #1. LPN #1 said s/he found Resident #1 in her room with no clothes on and tied to the bed with a sheet pulled across her body from below the breasts to the above her knees. All four corners of the sheet were tied with knots to the bed frame. LPN #1 said s/he calmly removed the sheet because s/he knew that the Resident #1 had anxiety and s/he didn't want to upset the resident more. LPN #1 said s/he did a full physical assessment of the resident and noted no trauma other than indentations in the resident's legs with noted [MEDICAL CONDITION] where the sheet had been tied down. LPN #1 said s/he helped clean, settle, and feed Resident #1 with the assistance of LPN #2. LPN #1 said that s/he and LPN #2 then addressed the situation with CNA #1 who stated that s/he had tied Resident #1 down with the sheet because Resident #1

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

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F 0604 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) had taken off her briefs and clothing multiple times already that day. CNA #1 said that s/he didn't want to have to keep cleaning Resident #1 and became angry when advised that this was abuse. LPN #1 stated that CNA #1 was immediately removed from the facility. LPN #1 said that LPN #2 helped confront CNA #1 but had offered no other information about Resident #1. LPN #1 stated that to her/his knowledge LPN #2 had not worked at the facility since the incident. Review of the employee list dated 7/28/2020 reflected that LPN #2 was a staff LPN, not an agency staff member. Review of the facility investigation of the incident of 7/18/2020 reflected that the DON had taken a statement from LPN #2 on 7/23/2020 by phone. LPN #2 did not return two calls for interview from the surveyor. During an interview with CNA #2 and CNA #3 at 3:55 p.m. the CNAs stated that they had worked with Resident #1 in the past and that Resident #1 required a lot of care and that Resident #1 was always tapping on the bedside table. Both CNAs said that they had been trained on abuse and neglect and knew that physical restraints were not allowed by facility policy. During an interview on 7/27/2020 at 4:00 p.m. LPN #3 stated that s/he worked a lot with Resident #2 and was aware of the incident on 7/18/2020. LPN #3 stated that Resident #1 required a lot of care and that s/he was often very anxious. LPN #3 stated that s/he was not working the day of the incident but when s/he came back to work s/he noticed Resident #1 had not been eating as much, so s/he had been concerned. LPN # 3 stated that s/he had been trained on abuse and neglect and knew that physical restraints were not allowed. During an interview on 7/27/2020 at 4:15 p.m. and on 7/28/2020 at 10:30 a.m. the DON stated it was the facility's responsibility to ensure that residents were free of physical restraints. The DON stated that all employees including agency staff received education about the facility policies and procedures prohibiting abuse, neglect, exploitation, and mistreatment of [REDACTED]. Review of the facility New Employee Orientation During COVID 19 updated April 3, 2020 reflected that new employees received training including on Systems Overview: Restraints, Creating a Restraint Free Environment, Managing Challenging Behaviors, Understanding [MEDICAL CONDITION] and Dementia, Preventing, Recognizing, and Reporting Abuse, and Abuse Policy and Procedures. Review of the facility's Contract/Vendor Orientation dated 2019 reflected that orientation included a section on restraints that referred the contract/vendor to the local, state, and federal regulations defining physical and chemical restraints. The orientation document also addressed abuse prevention including the prohibition of any form of abuse of residents. The orientation document addressed Behavior and Dementia Management. The orientation documentation specifically addressed the facility's prohibition of use of a physical restraint not required to treat a medical condition. The orientation document reviewed the definitions of abuse as defined by CMS section 483.5. The orientation document also noted the training that all employees including volunteers were to receive. The training included the required components for abuse prevention training: requirement for adequate supervision of staff in order to identify and prevent inappropriate behaviors including rough handling, ignoring the residents' needs requests, etc., and residents requiring excessive nursing care or staff attention. The orientation document noted the required component of Identification and noted that physical restraints (not required to treat a medical condition) constitute physical abuse. The orientation document included a Resident's Bill of Rights (South Carolina Code of Laws, Section 44-81-20 et. seq.) that defined the resident's right to be free from physical abuse and physical restraints (unless ordered by the doctor).
F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of facility policy, the facility failed to ensure a thorough investigation of an alleged incident of abuse was performed for one (1) of one (1) residents reviewed for abuse (Resident #1). Resident #1 was determined by facility investigation to have been physically restrained by a Certified Nursing Assistant (CNA) #1 causing harm to Resident #1. The facility did not ensure that other residents had not been affected and the facility did not ensure CNA #1 was referred to the appropriate licensing board. Findings include: Review of Resident #1's Face Sheet dated 7/27/2020 reflected [DIAGNOSES REDACTED]. Review of Resident #1's Annual Minimum Data Set ((MDS) dated [DATE] reflected a Brief Interview for Mental Status (BIMS) score of five (5) indicating severe cognitive deficit. The MDS reflected the requirement for extensive assistance with activities of daily living (ADLs) and that Resident #1 was incontinent of bowel and bladder. The MDS reflected that Resident #1 exhibited mood and behavior issues during the reporting review period. The resident's Personal Health Questionnaire-9 (PHQ-9) score of twelve (12) indicated moderate depression. Review of the facility 5-Day Follow Up Report dated 7/23/2020 reflected that Resident #1 was found on 7/18/2020 restrained in her bed with a bed sheet secured tightly across her body between the breasts and the knees and tied at all four (4) corners of the sheet to the bed frame, restricting Resident #1's ability to move. The facility staff took immediate action by releasing and assessing Resident #1, suspending the Certified Nursing Assistant (CNA) who had restrained Resident #1, notified the agency who had supplied the CNA, contacted the local police, and ensured that the CNA was not allowed to work in the facility again. The report of alleged abuse was filed by phone on 7/18/2020 within two (2) hours of the incident and by fax on 7/20/2020. An abuse investigation was initiated. The facility filed the follow-up report with the state on 7/23/2020. Review of the facility's investigation reflected that the facility obtained a statement from Licensed Practical Nurse (LPN) #1 who discovered Resident #1's restraints as well as a statement from LPN #2 who was a witness. The investigation did not include other witness statements or a screening of other residents who had received care by CNA #1 (who had restrained Resident #1). Review of staffing records showed that CNA #1, who had been provided by an agency, had worked at the facility on 7/11/2020, 7/12/2020, 7/17/2020, and on 7/18/2020 on different units. Review of the facility's Abuse, Neglect, Exploitation, or Mistreatment Policies and Procedures dated 11/1/2017 defined physical restraints (not required to treat a medical condition) as physical assault/abuse. The policy further reflected that mistreatment meant inappropriate treatment of [REDACTED]. The policy reflected the investigation may include but was not limited to written summaries of individuals having first-hand knowledge of the incident. The section of the policy, Guidelines for Investigation, reflected that other residents in the facility might be interviewed depending upon the incident, and that social service staff would provide support services to the resident and implement an interdisciplinary care plan. The policy also stated that the facility will report substantiated abuse to the appropriate licensing board. During an interview on 7/27/20 at 1:15 p.m., the Administrator and Director of Nursing (DON) stated that they had not reported the incident of substantiated abuse to the licensure registry. They said that they had told the agency who employed CNA #1 of the results of the investigation and the agency representative told them they would take care of it, but that they had not followed up to confirm the agency's actions. During an interview with the Administrator on 7/27/2020 at 4:30 p.m. the Administrator stated that CNA #1 was employed by the staffing agency and the agency was aware of the results of the investigation. The Administrator stated s/he thought the agency would make the required referral of the employee (CNA #1) to the licensure board. When asked about the facility's policy for abuse reporting, the Administrator verified it was the facility's responsibility to ensure CNA #1 was reported to the licensure board. The Administrator stated s/he would contact the staffing agency to confirm that the referral had been made. The Administrator stated the DON had led the investigation for the incident on 7/18/2020. During an interview with the DON on 7/27/2020 at 4:15 p.m. and on 7/28/2020 at 10:30 a.m. the DON stated the staffing agency was supposed to report the CNA to the licensure board. When asked about the facility's policy for abuse reporting, the DON verified it was the facility's responsibility to ensure that the substantiated abuse by CNA #1 was reported to the licensure board. The DON stated that s/he would confirm with the agency that the referral had been made. During an interview with the facility Social Worker (SW) on 7/28/2020 at 2:49 p.m. the SW stated s/he normally followed up on abuse incidents by interviewing other residents as a safety audit but did not do so in this case. S/he stated s/he had interviewed other residents for safety in the past but this time the Administrator and Director of Nursing (DON) performed the investigation. The SW stated s/he did not know what the policy stated regarding the responsibilities of the social services department for allegations of abuse. During an interview on 7/28/2020 at 3:06 p.m. the Agency Vice President (VP) sated that s/he was aware of the substantiated abuse allegation and that his/her in-house chief of nursing was handling the situation. S/he stated that s/he would email the facility with a status of the referral of the employee to the licensing board. During an interview with the DON 7/28/2020 at 4:45 p.m. the DON confirmed that the investigation file included all records of actions taken and interviews conducted for the incident of 7/18/2020.