STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425387	A. BUILDING _____ B. WING _____	**08/19/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RICE NURSING HOME	**100 FINLEY ROAD COLUMBIA, SC 29203**

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview and record reviews the facility failed to assure that a staff member observed proper placement of a facemask in relation to COVID-19 infection control guidelines during 1 of 5 staff observed during medication pass observations in the Arbor resident care building. The findings include: During medication pass observations, on 8/18/20 at 9:42 AM outside Arbor room [ROOM NUMBER], LPN (Licensed Practical Nurse) # 1 walked down hallway to the medication cart with entire mask hanging beneath his/her chin, not covering mouth or nose, as he/she peeled and ate a banana. The banana skin was placed in the medication cart waste bin as LPN # 1 carried on a conversation with LPN # 2 who was in the process of passing medications. He/she then walked away with the mask hanging beneath his/her neck. On 8/18/20 at approximately 11:30 AM the DON (Director of Nursing) stated that this was contrary to the Center for Disease Control and Center for Medicare & Medicaid Services Guidance for Wearing Masks-COVID-19 which the facility had adopted as policy. The DON stated that a facemask must be worn at all times over the nose and under the chin and that food is not allowed in the hallways, nursing station or on medication carts.

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