STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425146	A. BUILDING _____ B. WING _____	**08/23/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SANDPIPER REHAB & NURSING	**1049 ANNA KNAPP BOULEVARD MOUNT PLEASANT, SC 29464**

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, staff interviews, record review and facility policy review, the facility failed to enforce their infection control policies to help mitigate the transmission of Coronavirus 19 (COVID-19), by not assisting residents with hand hygiene before meals for 2 of 2 cognitively impaired residents (Resident #1 and Resident #2). The findings included: 1. Resident #1 was admitted with [DIAGNOSES REDACTED]. On the admission Minimum Data Set assessment (MDS), dated [DATE], Resident #1 was assessed as having severe cognitive impairment and required extensive assistance with personal hygiene. During a continuous observation on 08/23/20 on the Magnolia Hall, on 08/23/20 from 4:55 PM until 5:20 PM, Resident #1 was wearing a surgical mask while sitting in the dining room with four other residents. Before the dinner trays came out, Resident #1 had been asked by Licensed Practical Nurse (LPN) #1 to readjust her face mask and Resident #1 pulled it up, using her hands. Her hands were not cleaned afterwards. At 5:08 PM, Certified Nursing Assistant (CNA) #2 brought a meal tray to the table and began to set up the tray for Resident #1, opening containers. After CNA #2 walked away, Resident #1 began to feed herself. An interview was conducted with CNA #2 on 08/23/20 at 5:12 PM, who acknowledged that when she set up the tray for Resident #1, she did not sanitize the resident's hands, stating that she was a new employee and forgot. An interview was conducted with LPN #1 on 08/23/20 at 5:21 PM, who shared that staff use a container of wipes kept at the nurse's station to clean residents at hands. The container was still behind the desk, so the nurse placed it on the countertop. An interview was conducted with the Administrator on 08/23/20 at 6:30 PM, who expressed that her expectation was for staff to make sure that residents' hands were wiped before getting tray. 2. Resident #2 was admitted with [DIAGNOSES REDACTED]. On the admission MDS, dated on 08/08/20, Resident #2 was assesses as having severe cognitive impairment and required extensive assistance with personal hygiene. During a continuous observation on 08/23/20 on the Magnolia Hall, from 4:55 PM until 5:20 PM, revealed Resident #2 was wearing a surgical mask while sitting in the dining room, with four other residents. Before the dinner trays came out, Resident #2 had been asked by LPN #1 to readjust her face mask and Resident #2 pulled it up, using her hands. Her hands were not cleaned afterwards. At 5:10 PM, CNA #1 brought a meal tray to the table and began to set up the tray for Resident #2. After CNA #2 walked away, Resident #2 began to feed herself. An interview was conducted with CNA #2 on 08/23/20 at 5:16 PM, who stated that she had cleaned Resident #2's hands before the trays came out. When asked when that occurred, since the resident had been sitting in the dining room for a period of time, while the aide was still working on the hall. CNA #2 could not pinpoint a time. An interview was conducted with LPN #1 on 08/23/20 at 5:21 PM, who shared that staff use a container of wipes kept at the nurse's station to clean residents at hands. The container was still behind the desk, so the nurse placed it on the countertop. An interview was conducted with the Administrator on 08/23/20 at 6:30 PM, who expressed that her expectation was for staff to make sure that residents' hands were wiped before getting tray. A review on 08/23/20 was conducted of the facility's April 2001 policy, Preparing the resident for a meal stated to, Encourage the resident to wash his or her face and hands. Assist as needed. A further review on 08/23/20 was conducted on the New Employee Orientation Checklist, which highlighted that Infection Control-hand washing was covered. CNA #1 completed orientation on 07/07/20, whereas CNA #2 completed her training on the same material on 08/04/20. A review of Center for Disease Control (CDC) website on 08/28/20, provided guidance for patients to wash hands was added on 03/15/16. It stated under Hand Hygiene, when should you clean your hands: Before preparing or eating food; Before touching your eyes, nose or mouth.

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

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.