STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425146	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandpiper Post Acute	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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to provide a timely notification to the provider or nurse practitioner (NP) of the delayed delivery of a medication for 1 of 1 resident (Resident (R)172) in the sample of 33 residents. Specifically, R172 missed two doses of intravenous (IV) medication and there was no evidence in the medical record the provider or NP was notified. This deficient practice had the potential to affect the resident's health and recovery from sepsis.Findings include: Review of the facility's policy titled Reconciliation of Medication on admission dated 2017 revealed, Any medications not received timely from pharmacy the physician will be notified. Review of R172's electronic medical record (EMR) Face Sheet under Profile tab revealed an admission date of 06/02/26 and a discharge date of 06/05/26, with diagnoses including but not limited to Hepatic Biliary Necrosis (the localized death of bile duct tissues) and Septic Shock (a life-threatening immune system response to infection). Review of R172's Orders tab of the EMR revealed an order dated 06/02/26 for Piperacillin Sod-Tazobactam So Solution Reconstituted 4-0.5 GM (Use 4.5 gram intravenously every 6 hours for sepsis for 13 days). Review of the EMR Medication Administration Record (MAR) dated June 2026 revealed that the first dose of Piperacillin had been scheduled to be given on 06/02/26 at 6:00 PM. Further review of the MAR revealed that the Piperacillin Sod-Tazobactam So Solution Reconstituted 4-0.5 GM medication was scheduled for midnight on 06/03/26, however was documented by Licensed Practical Nurse (LPN)1 on 06/02/26 at 11:26 PM as medication on order. On 06/03/26 the medication was scheduled for 6:00 AM however was documented by LPN1 on 06/03/26 at 6:16 AM as pending arrival from pharmacy. The MAR indicated that on 06/03/26 at 1:42PM, the IV antibiotic was administered. Review of R172's EMR Progress Notes under the Progress notes tab dated 06/02/26 through 06/03/26 revealed no documentation that the provider or Nurse Practitioner (NP)1 was notified that the IV antibiotic medication Piperacillin was not available to be administered on 06/02/26 for the 6:00 PM dose, on 06/03/26 for the 12:00AM and 6:00 AM dose. During an interview on 06/29/26 at 10:22 AM, the Director of Nursing (DON) explained that R172's admission was on 06/02/26 at 7:00 PM. The DON explained the orders for all of R172's medications had been sent to the pharmacy on the admission date of 06/02/26. During a second interview on 06/29/26 at 6:10 PM, the DON explained that pharmacy acknowledged (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an error regarding the Piperacillin specifically that the order was not seen in the queue when it came in and consequently was missed. The pharmacist emailed the DON on 06/29/26 at 2:06 PM, a timeline which indicated, Order came in at 5:55 PM on 06/02/26, order was routed on the IV queue 06/02/26, order was entered as STAT [immediate] on 06/03/26 at 9:12 AM, order was delivered at 1:20 PM on 06/03/26 During a follow-up interview on 06/30/25 at 10:00 AM, the DON discussed the missed doses of Piperacillin saying, . the facility does not have an inhouse pharmacy or a pyxis. The DON stated that as soon as she got in on 06/03/26, a STAT (immediate delivery) was processed for the medication, and it was at that time the pharmacy acknowledged the mistake. During an interview on 06/30/26 at 10:00 AM, Registered Nurse (RN)1, who had been on duty for R172 the evening of his admission on [DATE], acknowledged the antibiotic was not available the evening of admission. On 06/30/26 at 3:30 PM an attempt to speak with LPN1 who had been on duty for R172 on 06/02/26 and 06/03/26. A phone message was left requesting a return call that was not returned during survey. During an interview on 06/30/26 at 6:10 PM, the DON explained that there had been no expectation of the medication coming in during the evening of 06/02/26 due to the lateness of the admission and entry of orders. The DON explained when she came in the following day and found out the medication had not come in immediate action was taken to notify NP1 and get the order entered as STAT. The DON said the medication was given as soon as it arrived. During a telephone interview on 06/30/26 at 6:31 PM, NP1 recalled the situation and explained there would have been no expectation for medication delivery the night of admission and that the DON had provided timely notification of delay the following day.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to protect 3 of 3 residents (Resident (R)2, R51 and R159) from physical abuse, out of a sample of 33 residents. Specifically, the facility enabled R68 to physically abuse R2, R51, and R159 by not properly supervising R68.On 06/29/26, the State Agency (SA) determined that the facility's non-compliance with one or more federal health, safety, and/or quality regulations has caused or was likely to cause serious injury, serious harm, serious impairment, or death. On 06/29/26 at 9:30 PM, the survey team provided the Administrator with a copy of the CMS Immediate Jeopardy (IJ) Template and informed the facility IJ existed as of 01/25/26. The IJ was related to 42 CFR 483.12 - Freedom from Abuse, Neglect, and Exploitation.On 06/30/26 at 1:06 PM, the facility provided an acceptable IJ Removal Plan. On 06/30/26 at 4:30 PM, the survey team, validated the facility's corrective actions and removed the IJ. The facility remained out of compliance at F600 at a lower scope and severity of E.An extended survey was conducted in conjunction with the Recertification and Complaint Survey for non-compliance at F600, constituting substandard quality of care.Findings include: Review of the facility's policy titled, Abuse and Neglect-Clinical Protocol revised 03/2018 revealed it is the policy of this facility for management and staff to institute measures to address the needs of the residents and minimize the possibility of abuse. Further review of the policy revealed Abuse is defined as the willful infliction of injury . Instances of abuse of all resident, irrespective of any mental or physical condition . It includes verbal abuse, sexual abuse, physical abuse . 1. Review of R2's Face Sheet located in the electronic medical record (EMR) under the Profile tab revealed the resident was admitted on [DATE], with diagnosis including but not limited to cognitive communication deficit. Review of R2's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/09/26 and located under the MDS tab of the EMR revealed a Brief Interview for Mental Status (BIMS) score of 00 out of 15, which indicated the resident was severely cognitively impaired. 2. Review of R51's Face Sheet located in the EMR under the Profile tab revealed the resident was admitted on [DATE], with diagnosis including but not limited to dementia. Review of R51's quarterly MDS with an ARD of 05/23/26 and located under the MDS tab of the EMR revealed a BIMS score of 10 out of 15 indicating a moderately impaired cognition. 3. Review of R68's Face Sheet located in the EMR under the Profile tab revealed the resident was admitted on [DATE], with diagnosis including but not limited to cognitive communication deficit. Review of R68's quarterly MDS with an ARD of 03/06/26 and located under the MDS tab of the EMR revealed a BIMS score of 15 out of 15 indicating cognitively intact. 4. Review of R159's Face Sheet located in the EMR under the Profile tab revealed the resident was admitted on [DATE] with diagnosis including but not limited to hyperlipidemia. Review of R159's quarterly MDS with an ARD of 05/06/26 and located under the MDS tab of the EMR revealed a BIMS score of 15 out of 15 indicating cognitively intact. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility's investigative file revealed that on 01/25/26, R68 hit R159. The file indicated that R159 was yelling and cursing at a female resident when R68 said to R159 to stop. R159 confronted R68 by cursing and replying with it's a black conspiracy. R68 struck R159 in the face. Review of R68's EMR Care Plan under the Care Plan tab indicated R68 had been educated that, I cannot hit or touch another resident even if I am defending another resident dated 01/25/26. Review of the facility's investigative file revealed that on 04/27/25, R68 punched R51 in the nose. R68 overheard R51 yelling and cursing at his roommate. R68 told R51 to stop yelling. R51 began yelling at R68. R51 stated that R68 punched him in the nose. Review of R68's EMR Care Plan under the Care Plan tab indicated R68 education and reminders that I have to stay in my room and not touch or address concerns with other residents and alert staff to my concerns dated 04/27/26. Review of the facility's investigative file revealed that on 05/25/26, R68 hit R2 who was yelling and cursing at a female resident. R68 told R2 to stop. R2 continued to point his finger in the female resident's face and curse; that is when R68 struck R2 once. Review of R68's Care plan in the EMR under the Care Plan tab indicated that Resident may customize smoking time to avoid being in group setting with other smokers dated 05/05/24 and revised on 06/29/26. During an interview on 06/29/26 at 2:35 PM, the Social Services Director (SSD) stated that R68 was still in the facility. The SSD stated that several attempts have been made to find placement at another facility that could better meet his needs. During an interview on 06/29/26 at 3:00 PM, the Director of Nursing (DON) confirmed that the facility did not place R68 on a one-to-one supervision as an intervention after each of the physical altercations involving R68 and R2, R51 and R159, because the residents were moved to other hallways away from R68. The DON stated that R68 was also put on one-to-one for smoke breaks to ensure there wasn't any contact between R68 and the other residents. During an interview on 06/29/26 at 8:29 PM, the DON stated that the incidents were described by R68 so there was no way the facility could prove that the others involved cursed another resident. The one female resident that R159 was accused of cursing was interviewed and told the DON when asked if R159 was being mean and cursing at her, the female resident stated, s**t no. During an interview on 06/29/26 at 4:32 PM, Nurse Practitioner (NP)1 stated that she does not think that R68 was a danger to himself or others. She had been working with R68 on communication instead of reaction. Has also provided R68 with self-awareness exercises to help with anxiety and impulse control. NP1 stated that she has also educated staff on monitoring for R68 signs of agitation and interventions such as the self-awareness reminders. NP1 stated that she does not feel R68 would benefit from adding any other medications to his regimen. On 06/30/26 at 1:06 PM, the facility provided an acceptable IJ Removal Plan, which included the following: Summary of Incident: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident 68 was involved in three resident to resident altercations with three other residents. He was involved in altercations on three separate occasions and with each altercation the facility acted accordingly and separated the residents and assessments were complete with no injuries noted. Plan of care was reviewed and revised each time and adjustments made to care plans. Psych NP f/u with Resident 68. Resident 68 does not participate in smoke breaks with the group and is provided separate smoke breaks and 1:1 supervision while smoking. Immediate Action Taken 1) Resident 68 was placed on 1:1 supervision on 6-29-26 @ 10pm following the IJ - care plan updated to reflect 1:1 and order in PCC. 2) Resident 159 was followed up with by DON on 6-29-26 for psychosocial support and states that he feels safe and I'm not afraid of anyone. No concerns voiced. 3) Resident 51 was followed up with by DON on 6-29-26 and he had no recollection of the altercation that occurred in April with another resident. When asked if he feels safe he says yes he does and voiced no concerns. 4) Resident 2 was seen by the DON for follow up on 6-29-26. He has no recollection of altercation that ocured in May with another male resident. He has no concerns and when asked if he feels safe he laughed and said yes. 5) Psych NP evaluated resident 68 on 6-30-26 to evaluate his physical aggression towards other residents. 6) Abuse policy reviewed by DON and Administrator. No revisions indicated. 7) 1:1 Supervision policy reviewed by DON and Administrator and revision indicated. ADHOC QA Meeting Held on 6-30-26 Members present were: [name] LNHA, [name] RN, DON, [name] SSD, Unit Managers and [name] NP Members via phone: [name] MD, Medical Director Root Cause: Staff failed to protect residents from abuse by Resident 68 with subsequent altercations with other residents. Education and training was provided to DON and Administrator by Regional Director of Clinical Services on 6-30-26 regarding Abuse and Abuse reporting and De-escalating behaviors and intervening with behaviors. Education was initiated on 6-30-26 by DON and Administrative Nursing staff for all staff regarding abuse and abuse reporting and intervening when any resident is anxious, yelling and cursing to deescalate the situation . As of 11:15 am on 6-30-26- 114 employees out of 176 have received the education. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	All newly hired staff and or agency staff will receive the education during next scheduled shift. Staff will also be educated on process of 1:1 supervision and documenting that supervision for Resident 68. Resident 68 was placed on 1:1 supervision effective 10pm on 6-29-26 and has had no concerns. 1:1 supervision Observation Checklist created for staff to provide documentation during supervision. Plan of care reviewed and revised for Resident 68 to include 1:1 supervision. SSD/Administrator and DON will continue to meet with Resident 68 and his daughter and referrals will continue to be made to other facilities for discharge planning . Audits by DON/designee will be complete daily Mon-Fri as part of Clinical meeting process to review all nursing notes to ensure any behaviors or verbal altercations were handled and documented appropriately Audit of 1:1 supervision documentation will be reviewed daily by DON/designee . Resident 68 was seen by Psych NP on 6-30-26 to educate and evaluate him regarding physical aggression towards other residents. Results of QAPI will be reviewed by QA committee weekly x 2 weeks then monthly x1 then quarterly as needed to ensure no further need for monitoring. The above components have been implemented as of 6-30-26 by 1:46pm