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	04/10/2025

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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 32513 Based on interview and record review, the facility failed to ensure the previous three years of surveys, complaint investigations and any plans of corrections were made readily accessible to residents, families, or visitors. This failure placed all the residents, families, and visitors at risk of not being provided with information on the facility's quality of care. Findings included: During a tour of the facility on 04/08/25 at 4:29 PM, the survey book, which was located on the wall at the entrance to the activity room, revealed no previous surveys, certifications, complaint investigations and any plans of correction between 2022 and present. Review of the [NAME] [an acronym for Certification and Survey Provider Enhanced Reporting] report revealed the following surveys and complaint investigations occurred at the facility since 2022: May 2023 a federal survey with citations and the plan of correction; 08/27/24 complaint investigation which was substantiated and the plan of correction; 10/09/24 complaint investigation which was unsubstantiated; 11/21/24 complaint investigation which was substantiated and the plan of correction; 01/28/25 complaint investigation which was substantiated and the plan of correction; and an 04/18/24 federal survey with citations and the plan of correction. During an interview on 04/08/25 at 4:38 PM, the Administrator and Director of Nursing (DON), who reviewed the survey book, confirmed that it had not been updated with the required information for the past three years.

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 26446 Based on observation, staff interview, and facility document review, the facility failed to maintain a safe and homelike environment, including but not limited to ensuring maintenance services were conducted as necessary to maintain a sanitary, orderly, and comfortable interior. Specifically, the bedroom walls were gauged and scraped and the bathroom door had scuff marks and was unable to open fully. This deficient practice affected eight resident (R)76, R141, R147, R17, R82, R35, R145 and R96) in the census of 151. The facility failed to provide a homelike environment and easy access in and out of resident rooms and bathrooms. Findings include: The undated Common Area Checklist revealed, General and Common Area items to review daily. These items include monitoring doors, walls, trims, baseboards, and flooring. During an observation on 04/08/25 at 10:00 AM, R76's room revealed extensive and deep wall scrapings along the side of the resident bed. During an observation on 04/08/25 at 10:08 AM, the bathroom door for R82 and R35's room could not open more than approximately half-way before being jammed along the floor, leaving large scuff marks on the resident room floor. During an observation on 04/08/25 at 11:53 AM, R141's room revealed extensive and deep wall scrapings along the side of the resident's bed. During an observation on 04/08/25 at 12:40 PM, R147's room revealed extensive and deep wall scrapings across the majority of the resident's wall. During an observation on 04/08/25 at 1:30 PM, the front door to R145 and R96's room could not open more than approximately half-way before being jammed along the floor, leaving large scuff marks on the resident room floor. During an observation on 04/09/25 at 8:45 AM, R17's room revealed extensive and deep wall scrapings across the resident room walls. Interview during a facility tour on 04/10/25 from 5:12 PM through 5:35 PM, the Maintenance Director (MD) stated he used an electronic system to complete work orders. He stated that if the nurses and certified nurse aides (CNA) found a concern, the nurses had access to this system. During the facility tour the MD confirmed that the doors had shifted and some had become damaged, and that they needed replaced or repaired. He confirmed the room walls needed repaired and painted. He stated that he had a checklist that he used each day to ensure facility building needs were met.

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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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32513 Based on interview, record review, and review of the Resident Assessment Instrument (RAI) manual, the facility failed to ensure a significant change Minimum Data Set (MDS) was completed for one resident (Resident (R)87) of two sampled residents reviewed for hospice in a total sample of 34. The facility failed to complete the significant change assessment when R87 revoked hospice services due to an improvement in his condition. This failure placed residents at risk of unmet care needs and a diminished quality of life. Findings included. Review of the RAI manual version 3.0 dated October 2024, page 2-25 revealed, .An SCSA [significant change in status assessment] is required to be performed when a resident is receiving hospice services and then decides to discontinue those services (known as revoking of hospice care). The ARD [assessment reference date] must be within 14 days from one of the following: 1) the effective date of the hospice election revocation (which can be the same or later than the date of the hospice election revocation statement, but not earlier than); 2) the expiration date of the certification of terminal illness; or 3) the date of the physician's or medical director's order stating the resident is no longer terminally ill . Review of the Admission Record located in the Profile tab of the electronic medical record (EMR) revealed R87 was readmitted to the facility on [DATE] with a diagnosis of anoxic brain damage (lack of oxygen to the brain). Review of the Order Summary located in the Orders tab of the EMR revealed, Admit to [hospice name withheld] dated 11/26/24. Review of the significant change MDS located in the MDS tab of the EMR with and ARD of 12/05/24 revealed R87 had a Brief Interview of Mental Status (BIMS) score of six out of 15 which indicated R87 was severely impaired in cognition and was receiving hospice care. Review of the quarterly MDS located in the MDS tab of the EMR with an ARD of 03/02/25 revealed, R87 had a BIMS score of nine out of 15 which indicated R87 was moderately impaired in cognition and was receiving hospice services. Review of the provider visit note dated 03/27/25 in the EMR under the Progress Notes tab revealed that R87 revoked hospice services due to Being stable and gaining weight. During an interview on 04/08/25 at 10:46 AM, R87 was asked if he was still on hospice services. R87 stated, No, I quit hospice. They told me I had six months left to live but that has been over a year ago and I am still here. During an interview on 04/10/25 at 10:57 AM, the MDS Director (MDSD) was asked when had R87 had revoked hospice services. The MDSD stated, He went off hospice on 02/19/25. The MDSD was asked why a quarterly assessment was completed instead of a significant change assessment. The MDSD stated, I was not aware that a significant change assessment needed to occur when a resident goes off hospice. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/08/25 at 4:06 PM, the Director of Nursing (DON) stated, R87 came off hospice care on 02/29/25. The DON confirmed that a significant change assessment had not been completed.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28154 32513 Based on interview, record review, and review of the Resident Assessment Instrument (RAI) manual, the facility failed to ensure the Minimum Data Set (MDS) was coded accurately for two (Residents (R)87 and R135) in a total sample of 34. The facility failed to accurately code a significant change assessment for prognosis of terminal illness for R87 and for mental status for R135. These failures placed the residents at risk of unmet care needs and a diminished quality of life. Findings included. Review of the October 2024 RAI manual, page 1-5 revealed, .An accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations .It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident's actual status was during the observation period) by the IDT (interdisciplinary team) completing the assessment . Review of the October 2024 RAI Manual, page C-1, revealed: Cognitive Patterns.Steps for Assessment, 1. Interact with the resident using their preferred language . Be sure they can hear you and/or have access to their preferred method for communication. If the resident needs or requires an interpreter, complete the interview with an interpreter. If the resident appears unable to communicate, offer alternatives such as writing, pointing, sign language, or cue cards. 2. Determine if the resident is rarely/never understood verbally, in writing, or using another method . 1. Review of R87'sAdmission Record located in the Profile tab of the electronic medical record (EMR) revealed R87 was readmitted to the facility on [DATE] with a diagnosis of anoxic brain injury and blood clots to both upper extremities. Review of the Order Summary located in the Orders tab of the EMR revealed, Admit to [hospice name] dated 11/26/24. Review of R87's significant change MDS located in the MDS tab of the EMR with an ARD of 12/05/24 revealed, R87 had a Brief Interview of Mental Status (BIMS) score of six out of 15 which indicated R87 was severely impaired in cognition, was not coded for prognosis of six months or less but was on hospice care. Review of the Certification of Terminal Illness (CTI) located in the Documents tab of the EMR revealed, R87 had a terminal diagnosis of six months or less which was signed by the physician. The CTI was dated 11/26/24 to 02/19/25. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/10/25 at 10:57 AM, the MDS Director (MDSD) was asked why the prognosis of six months or less was not coded but hospice care was coded. The MDSC stated, I did not see the hospice documentation because it was not uploaded to the computer until 12/31/24. The MDSD further stated she was not aware that to be on hospice care required a terminal diagnosis of six months or less. 2. Review of R135's Admission Record from the EMR Profile tab showed a facility admitted [DATE] with medical diagnoses of senile degeneration of the brain, cognitive communication deficit, and history of cerebral infarction. Review of R135's annual MDS in the EMR MDS tab with an ARD of 10/04/24 showed a BIMS score of 12 out 15, indicative of moderate cognitive impairment. Review of R135's quarterly MDS with an ARD of 01/02/25 was coded as Rarely or Never Understood. Section C200 to C400 was not scored and Section C500 BIMS summary score was not completed. Section C600, should the staff assessment for mental status be conducted, it was not scored for either No (resident was able to complete interview) or Yes (resident was unable to complete interview). Review of R135's MDS with an ARD of 04/01/25 showed a BIMS score of 13 out of a possible 15, indicative of being cognitively intact. During an interview on 04/10/25 at 11:40 AM, the MDS Director (MDSD) reviewed R135's assessments and stated, I don't know what happened. That one [01/02/25] was a mistake; he is with it. When asked if R135 was cognitively intact in January, the MDSD responded Yes. When queried if the facility had an MDS accuracy policy, the MDSD stated, No, we use the RAI [Resident Assessment Instrument] manual. I didn't verify the MDS information. I just sent it out.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39540 Based on observation, interview, record review, and policy review, the facility failed to ensure a baseline care plan was accurate and complete within 48 hours of admission to the facility for one of nine residents (Resident (R)412) reviewed for care plans in the sample of 34 residents. The deficient practice had the potential for the lack of care planning for the specific needs of the residents. Findings include: Review of the facility's policy titled Care Plans-Baseline revised 12/22 revealed, A baseline plan of care should be developed for each resident within forty-eight (48) hours of admission. The baseline care plan should include instructions needed to provide effective, person-centered care of the resident . Review of R412's Admission Record located in the EMR under the Profile tab, revealed an admitted [DATE] with a readmitted [DATE] with medical diagnosis that included end stage renal disease (ESRD) Observations on 04/08/25 at 5:30 PM revealed R412 had a gastrostomy tube (G-tube) inserted in the abdomen, a central venous catheter (CVC) inserted in the right chest wall, and a continuous positive airway pressure (CPAP) machine located on the nightstand near the resident bed. Review of R412's Care Plan under the Care Plan tab in the EMR documented a care plan focus for dialysis with interventions for peritoneal dialysis with an initiation date of 03/26/25 and lacked care plan for a G-tube and for CPAP. During an interview on 04/09/25 at 1:36 PM, Licensed Practical Nurse (LPN)3 reviewed the EMR and confirmed the care plan indicated the wrong type of dialysis. R412 was receiving hemodialysis not peritoneal dialysis since R412 had CVC for dialysis treatment. LPN3 verified R412 had a G-tube and CPAP and there was no care plan. During an interview on 04/10/25 at 7:59 AM, Infection Preventionist/Unit Manager (IP) confirmed R412 had been wearing the CPAP machine at 5:50 AM that day. During an interview on 04/10/25 at 11:13 AM, Director of Nursing (DON) and IP verified the care plan did not reflect R412's care needs. The DON confirmed the dialysis focus was incorrect, there was no care plan for the G-tube or CPAP and should be.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26446 Based on observation, record review, interviews, and facility policy review, the facility failed to implement a person-centered comprehensive plan of care with measurable goals for one of 34 sampled residents (R) 16) reviewed for care plans. The failure to implement the care plan intervention for pressure ulcers of a cushion to the resident's wheelchair placed the resident at risk of an ongoing decline in healing of the pressure ulcers. Findings include: Review of the facility's policy titled, Care Plans, Comprehensive Person-Centered dated March 2022 indicated, .A comprehensive, person-centered care plan should include measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs . The care plan interventions should be derived from information obtained from the resident and his/her family/responsible party, with possible discretionary modifications resulting from the comprehensive assessment .The comprehensive, person-centered care plan should: Describe the services that are to be furnished in an attempt to assist the resident attain or maintain that level of physical, mental, and psychosocial wellbeing that the resident desires or that is possible. Review of R16's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 03/20/25 located in the MDS tab of the Electronic Medical Record (EMR) revealed an admitted [DATE], a Brief Interview for Mental Status (BIMS) score of twelve out of 15, indicating he had moderate cognitive impairment. R16 was admitted with diagnoses including multiple sclerosis and muscle weakness. R16 was documented to require partial/moderate assistance for sitting to lying and was dependent for sit to stand and chair/bed-to-chair transfer. R16 was documented to have a stage three pressure ulcer. Review of R16's EMR titled physician Orders located under the Orders tab dated 01/09/23 indicated the resident was ordered a DEVICE: ROHO cushion to wheelchair (per wound specialist). Review of R16's EMR titled Care Plan located under the Care Plan tab initiated 08/04/17 revealed, the resident was at risk for skin impairment and/or breakdown .had a history of an open area to left toes and a wound to right/left buttock. Interventions included having a ROHO cushion on his wheelchair. During an interview on 04/08/25 at 10:20 AM, R16 stated that his current wheelchair was being replaced because the back support was not functioning properly anymore. His wheelchair was placed directly next to the resident bed. There was no cushion observed in the resident's wheelchair as care planned. During an interview and observation on 04/08/25 at 12:45 PM, R16 was observed seated in his new wheelchair. He stated he liked to be out of bed as much as possible, and stated the wheelchair could be more comfortable since he did have a wound on his bottom. He confirmed he did not have a cushion underneath him. None was visible. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation on 04/09/25 at 2:20 PM, R16 was noted in his wheelchair without a cushion. He stated he did not have a cushion in his wheelchair. During a concurrent interview on 04/09/25 at 2:30 PM, Licensed Practical Nurses (LPN)8 and LPN11 stated that R16 had a pressure ulcer on the sacrum. LPN8 stated that R16 would benefit from a wheelchair cushion since he liked to get out of bed. LPN8 reviewed the EMR and stated that it appeared an order had been placed into the chart, but it was not on the Medication Administration Record or Treatment Administration Record. During an interview and observation on 04/09/25 at 2:30 PM, Licensed Practical Nurse/Unit Manager (LPN)15 stated that R16 had a sacral wound. Upon observation of R16, LPN15 confirmed R16 was not using a cushion in his wheelchair. During an interview on 04/10/25 at 4:57 PM, the Director of Nursing stated that she expected the nursing staff to follow the resident's care plan and physician orders for the ROHO cushion for R16's wheelchair.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32513 Based on observations, interview, and record review, the facility failed to ensure the Comprehensive Care Plan was revised/updated for one resident (Resident (R)87) in a total sample of 34 care plans reviewed. Specifically, the facility failed to update the care plan when R87 revoked hospice services, had the gastrostomy tube (G-tube-a tube placed into the abdomen for medications and nourishment) removed and had the enhanced barrier precautions (EBP) removed. This failure placed the resident at risk of unmet care needs and a diminished quality of life. Findings included. Review of the Admission Record located in the Profile tab of the electronic medical record (EMR) revealed R87 was readmitted to the facility on [DATE] with a diagnosis of anoxic brain injury (lack of oxygen to the brain). Review of the quarterly Minimum Data Set (MDS) located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 03/02/25 revealed a Brief Interview of Mental Status (BIMS) score of nine out of 15 which indicated R87 was moderately impaired in cognition, was independent with eating, required partial assistance with toileting, bed mobility and transfers, had weight gain, no tube feedings, and was receiving hospice services. Review of the End-of-Life Care Plan dated 11/25/24 revealed, Resident requires comfort care and is at risk for rapid decline in ADL [activities of daily living] function, sudden onset or worsening skin integrity, weight loss, nausea/vomiting, pain, abnormal breathing, impaired psychosocial well-being related to terminal illness. Interventions included, Coordinate residents' needs with hospice staff, hospice service as ordered and notify hospice of change of condition. During an interview on 04/08/25 at 10:46 AM, R87 was alert, able to communicate and make his needs known. R87 was asked if he was currently in hospice. R87 stated, No, I quit hospice as they told me I had six months to live and that has been over a year ago, and I am still here. During an interview on 04/08/25 at 4:06 PM, the Director of Nursing (DON) confirmed R87 revoked hospice services 02/19/25. The DON confirmed that the Care Plan was not updated/revised when he went off hospice. Review of the Aspiration/Choking/Swallowing Care Plan dated 11/25/24 revealed, Resident is at risk for aspiration, choking, or difficulty swallowing related to chewing problems, coughing or choking during meals or when swallowing medications, Dysphagia [difficulty swallowing], G-tube, Gastroesophageal reflux disease (GERD), history of aspiration pneumonia, holding food in mouth/cheeks or residual food in mouth after meals, loss of liquids/solid from mouth while eating or drinking, swallowing problems .continue enteral feedings (nourishment via G-tube) for nutritional needs, allowed pleasure foods per hospice. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a discontinued/completed Order Summary located in the Orders tab of the EMR revealed, .PEG [percutaneous endoscopic gastrostomy] tube to remain out. Give all medications orally . dated 12/28/24. During an observation on 04/08/25 at 12:38 PM, R87 was observed at the dining table during the noon meal, feeding himself a regular meal and no swallowing issues were observed. Review of the Enhanced Barrier Precautions Care Plan dated 11/24/24 located in the Care Plan tab of the EMR revealed, .Resident requires enhanced barrier precautions during high-contact resident care activities due to the presence of .feeding tube . During an interview on 04/10/25 at 11:01 AM, the MDS Director (MDSD) reviewed R87's current care plan and stated, When R87 came off hospice, the care plan should have been revised as he no longer has the feeding tube and does not need EBP.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36190 Based on observation, interview, record review, and policy review, the facility failed to investigate the possible underlying issue for significant weight loss and assessed the resident before the use of a psychotropic drug for weight loss for one (Resident (R)51) of 10 sampled residents reviewed for nutritional status. This had the potential to cause further weight loss. Findings include: Review of the facility's policy titled, Weight Assessment and intervention revised 03/22 revealed, Weight Assessment .3. Any weight change of 5% or more since the last weight assessment is retaken the next day for confirmation. a. If the weight is verified, nursing will immediately notify the dietitian in writing.Evaluation, 1. Undesirable weight change is evaluated by the treatment team whether or not the criteria for significant weight change has been met. 2. The physician and the multidisciplinary team identify conditions and medications that may be causing anorexia, weight loss or increasing the risk of weight loss. Review of the facility's policy titled, Nutritional Assessment revised 10/17 revealed, 2. As part of the comprehensive assessment, the nutritional assessment will be a systematic, multidisciplinary process that includes gathering and interpreting data and using that data to help define meaningful interventions for the resident at risk for or with impaired nutrition. Review of R51's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 03/01/25 located in the MDS tab of the Electronic Medical Record (EMR) revealed an admitted [DATE], a Brief Interview for Mental Status (BIMS) score of five out of 15, indicating he was severely cognitively impaired, weight at 195 pounds, no weight loss, and had diagnosis of non-Alzheimer's dementia, schizophrenia, and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. Review of R51's 50% or less meal consumption and/or refusal: (Alternate meal/nourishments) located in the EMR under the Task tab revealed no nutritional supplement for 03/09/25 to 04/08/25. Review of R51's orders located in the EMR under the Order tab revealed the April 2025 Medication Administration Record (MAR)/Treatment Administration Record (TAR) and physician orders revealed no nutritional supplementation. Review of R51's progress notes dated 03/10/25 to 04/02/25 in the EMR under the Progress Note tab revealed no nutritional supplementation. Review of R51's orders located in the EMR under the Order tab revealed NAS [No Added Salt] diet, Mechanical Soft Chopped texture, Thin Liquids consistency dated 06/17/24 and Mirtazapine Oral Tablet 7.5 MG [milligram] (Mirtazapine) Give 7.5 tablet by mouth one time a day for appetite, dated 03/31/25. (continued on next page)

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	04/10/2025

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Sandpiper Post Acute	1049 Anna Knapp Boulevard Mount Pleasant, SC 29464

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R51's care plan revised 01/11/24 located in the EMR under the Care Plan tab revealed, Resident is at risk for malnutrition r/t [related to] h/o [history of] significant changes, therapeutic diet, dysphagia, dementia, Dx [diagnosis] Subdural hemorrhage, CVA [cerebral vascular accident] late effects, HTN [hypertension], HLD [hyperlipidemia], Mild cognitive deficit, ETOH [alcohol] abuse, Peptic ulcer disease (PUD), Hepatitis C, constipation, diuretic therapy, malnutrition risk. Interventions included, Provide and serve supplements as ordered .RD [Registered Dietician] to evaluate and make diet and nutrition-related recommendations PRN [as needed]. Review of R51's Nutritional Risk Review dated 06/03/24, located in the EMR under the Evaluation tab revealed Order for 1:1 feeding assistance started 5/31. He has dysphagia and is receiving mech [mechanically] altered diet. Pureed diet started 5/28/24 per hospital recommendations. Receives meds [medications] crushed per 5/30 nursing note. Review of R51's Nutritional Risk Review dated 03/20/25 located in the EMR under the Evaluation tab revealed, Has dysphagia and is receiving mech altered diet. Noted to need assistance with meals.Flagged for significant weight loss of -10% x30 days. Question accuracy of 3/10 weight. Other weights have been stable. Review of R51's weight history located in the EMR under the Weight/Vitals tab revealed a 17.8-pound (8%) weight loss in three months: On 01/03/25 at 198.0 pounds (Lbs.) via wheelchair On 02/04/25 at 195.2 Lbs. via [name of mechanical lift] On 03/10/25 at 175.6 Lbs. via wheelchair On 04/02/25 at 178.0 Lbs. via [name of mechanical lift] On 04/10/25 at 180.2 Lbs. On 04/09/25 at 8:24 AM, R51 was asleep in bed with his breakfast tray on an overbed table. R51's breakfast tray included a carton of milk, an English muffin, grits, egg omelet, chopped sausage, juice, and coffee. Zero percent of the food was consumed. On 04/09/25 at 8:30 AM, Certified Nurse Aide (CNA)4 was in R51's room standing at his bedside spoon feeding R51. On 04/09/25 at 8:33 AM, CNA4 was observed bringing R51's breakfast tray out of the room and onto the cart. CNA4 was asked about R51's meal consumption. CNA4 stated R51 ate 50% and then uncovered the plate to reveal 50% of the meal consumed. On 04/09/25 at 1:21 PM, CNA6 brought R51's lunch tray into his room and CNA spoon fed R51 in bed while standing at his bedside. R51 was served ground country fried steak, peas, mashed potatoes, baked apples, and milk. R51 ate 50% of the food and only bits of the ground country fried steak. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/09/25 at 5:02 PM, the RD was asked about R51's significant weight loss and his weights not taken consistently as sometimes a mechanical lift was used and other times a wheelchair. The RD stated she had asked nursing about the weights when she started working at the facility in late December 2024 and education was started for weigh consistency. The RD was asked if reweights should be completed if weights varied from the previous weight. The RD stated she asks nursing to do them. The RD stated R51 was someone she would have wanted reweighed and to conduct a deeper investigation as to why he is losing weight. The RD was asked about the Mirtazapine and if R51 was receiving supplements. The RD stated she had not yet recommended a supplement as she will consider a supplement after R51 was reweighed and investigate if it may be beneficial. The RD stated she also wanted to observe R51 while eating a meal. During an interview on 04/10/25 at 2:52 PM, the Nurse Practitioner (NP) was asked if she was aware of R51's recent significant weigh loss. NP stated she was aware R51 was steadily losing weight. NP was asked why R51 was losing weight. NP stated R51 was small, and then reviewed EMR quoting a weight from 2021. NP stated she put R51 on Mirtazapine as a response to R51's weight loss. NP had no further comment. During a follow up interview on 04/10/25 at 3:04 PM, the RD stated R51 was reweighed at 180.2 Lbs. on 04/10/25 and confirmed the reweight should have been sooner. The RD was asked why the NP used pharmacological intervention first. The RD stated she didn't know as she wasn't contacted. The RD confirmed nonpharmacological interventions (NPI) such as nutritional interventions should be attempted first before considering pharmacological interventions. During an interview on 04/10/25 at 5:00 PM, the Director of Nursing (DON) was asked if she was aware of R51's weight loss. The DON stated, don't know off the top of my head. The DON stated they didn't have a process to identify weight loss or at risk for weight loss but one was being developed. The DON was asked if she was aware R51's 2024 hospital discharge instructions recommended R51 have a pureed diet but R51 was on a mechanical soft diet. The DON stated, No. The DON was asked about the kitchen not having menu extensions for therapeutic diets. The DON stated she had heard something about that. The DON stated her expectation would be for staff to promptly inform her of weight loss and staff to follow their policy for reweighing a resident when the weight differed from the previous weight. The DON stated she was aware that weights should be taken consistently. During a follow up interview on 04/10/25 at 6:30 PM, the DON was asked why R51 was prescribed Mirtazapine first and not NPI as well as conducting an evaluation before using a psychotropic medication. The DON reviewed the EMR, and confirmed no evaluation was found. The DON stated she could not say why.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39540 Based on observation, interview, resident record, and facility policy, the facility failed to ensure residents receiving dialysis treatments, staff were using Enhanced Barrier Protection (EBP) when providing direct resident care for two of three residents (Resident (R) 113 and R412) reviewed for dialysis care. The facility failed to ensure physician orders were in place for dialysis treatment and accurate interventions were documented in the care plan. The deficient practice has the potential for the residents to not receive dialysis care in the facility. Findings included: Review of the facility's policy titled End-Stage Renal Disease, Care of a Resident dated 09/19 revealed, Residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care. Staff caring for residents with ESRD, including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents. Education and training of staff includes, specifically: the care of grafts and fistulas. The resident's comprehensive care plan will reflect the resident's needs related to ESRD/dialysis care. Review of the facility's policy titled Enhanced Barrier Precautions revised 03/24, revealed EBPs are (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required. 1. Review of R113's Admission Record located in the EMR under the Profile tab revealed an admitted [DATE] with medical diagnosis that included chronic kidney disease, stage three. Observation on 04/08/25 at 1:30 PM, R113 was in bed and pointed to his right chest when questioned about where the dialysis clinic accessed for dialysis. No signs on the door or near the resident room indicating the need for EBP. During an observation on 4/10/25 at 9:33 AM, Licensed Practical Nurse (LPN)13 confirmed the central venous catheter (CVC) catheter was located on the right chest wall by moving the resident's clothing to reveal the dressing. LPN13 was not wearing gloves at the time of the observation of the dressing. During an interview on 04/10/25 at 9:50 AM, LPN1/Unit Manager confirmed 113 should be on EBP and was not. 2. Review of R412's Admission Record located in the EMR under the Profile tab revealed an admitted [DATE] with a readmitted [DATE] with medical diagnosis that included end stage renal disease (ESRD) Review of R412's physician orders in the EMR under the Orders tab lacked documentation for an order for dialysis to include place and days for dialysis treatment. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R412's physician orders under the Orders tab in the EMR documented an order dated 03/26/25 for Gentamicin Sulfate external ointment 0.1 percent (%). Apply to peritoneal dialysis (PD) catheter topically every evening shift. Use gauze to apply Q tip sized amount. Review of R412's EMR MAR for March 2025 documented the gentamicin applied to PD catheter on five evening shifts and the MAR for April 2025 documented the gentamicin applied to PD catheter on nine evening shifts Review of R412's care plan under the Care Plan tab in the EMR dated 03/26/25, revealed, Resident requires peritoneal dialysis . and is at risk for bleeding at the access site, deficient/excess fluid volume, hypertension, occlusion, and shortness of breath. Interventions included monitor peritoneal access site [every] shift for redness, swelling, discharge, odor of pain. The care plan lacked focus and interventions for hemodialysis. During an interview on 04/08/25 at 2:00 PM, R412's family member (FM)1 explained that the resident went out for dialysis treatment because the PD catheter had been removed from the abdomen during the hospitalization prior to being admitted to the facility. Observation on 04/08/25 at 5:06 PM, Certified Nursing Assistant (CNA)1 came into R412's room for brief change. CNA1 applied gloves and did not apply any other personal protective equipment (PPE) prior to changing the brief. During an interview on 04/09/25 at 1:40 PM, Licensed Practical Nurse (LPN)3 verified the order for gentamicin for R412 and confirmed the PD catheter had been removed. LPN3 verified the site was healed and no longer needed the order for gentamicin to be applied. LPN3 verbalized documentation of the application of gentamicin being applied was not correct documentation. LPN3 confirmed R412 needed to be on EBP. During an interview on 04/10/25 at 11:00 AM, the Director of Nursing (DON) and the Infection Preventionist/Unit Manager (IP) both confirmed R113 had a CVC inserted in the right chest wall for dialysis access. Residents with CVC do not have a bruit or thrill present to be monitored. Monitoring needed was for dressing to be dry and clear, catheter secure. Documentation for presence of bruit and thrill for R113 was inaccurate, false documentation since with a CVC catheter the resident does not have a thrill or bruit. The DON and IP confirmed R412 did not have a peritoneal dialysis catheter and the order to apply gentamicin to the PD site on the abdomen was incorrect. Both confirmed the documentation about application of gentamicin to the PD catheter was inaccurate documentation. The DON and IP confirmed residents for dialysis were to be on EBP wearing gown and gloves during direct resident contact and residents requiring dialysis treatment required a physician's order.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26446 Based on interviews, record reviews, and policy review, the facility failed to ensure that one out of five residents (Resident (R) 145) out of a total sample of 33 residents reviewed for unnecessary medication use. Specifically, the facility failed to follow adequate monitoring of blood pressure parameters before the unnecessary administration of blood pressure medications, according to physician orders. This failure had the potential to increase the risk for serious adverse effects. Findings include: Review of the facility's policy titled, Administering Medications dated April 2019 indicated, Medications are administered in a safe and timely manner, and as prescribed .Medications are administered in accordance with prescriber orders, including any time frame.1. Review of R145's Admission Record found in the Profile tab of the electronic medical record (EMR) revealed she was admitted to the facility on [DATE] with diagnoses of atrial fibrillation, localized hypertensive chronic kidney disease, and edema. Review of R145's quarterly Minimum Data Set (MDS) assessment located in the MDS tab in the EMR with an Assessment Reference Date (ARD) of 03/14/25 revealed a Brief Interview for Mental Status (BIMS) score of five out of 15 which indicated severe cognitive impairment. R145 received a diuretic. Review of R145's Care Plan in the EMR under the Care Plan tab initiated 12/14/24, revealed R145 was at risk for complications related to a diagnosis of congestive heart failure as manifested by confusion, elevated blood pressure, and localized edema. Interventions included to administer medications as ordered. Record review revealed a cardiology appointment dated 02/20/25 that stated R145 was mild-moderately volume overloaded during exam and that the facility should complete vital signs daily. Review of R145's EMR under the Orders tab revealed an order, dated 12/16/24, for Vital Signs Q shift [every shift] while skilled every shift. This order was discontinued 03/01/25. Review of R145's February 2025 Medication Administration Record (MAR) in the EMR revealed resident received Amlodipine Besylate Oral Tablet 10 milligrams (mg). Give one tablet by mouth one time a day for hypertension at 9:00 AM. Hold if systolic blood pressure (SBP) less than 100. The medication was documented as administered, but SBP was not documented each day prior to administration. Record review of R145's March 2025 MAR in the EMR revealed resident received Amlodipine Besylate oral tablet 10 mg one tablet daily. The medication was documented as administered, but SBP was not documented each day prior to administration. Record review of R145's April 2025 MAR in the EMR revealed resident received Amlodipine Besylate oral tablet 10 mg one tablet daily. The medication was documented as administered, but SBP was documented only on 04/09/25, as of 04/09/25. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of R145's February 2025 MAR in the EMR revealed resident received Furosemide oral tablet 40 mg. Give one tablet by mouth one time a day for congestive heart failure at 9:00 AM. Hold if SBP (systolic blood pressure) less than 100. The medication was documented as administered, but SBP was not documented each day prior to administration. Record review of R145's March 2025 MAR in the EMR revealed resident received Furosemide oral tablet 40 mg one tablet daily. The medication was documented as administered, but SBP was not documented each day prior to administration. Record review of R145's April 2025 MAR in the EMR revealed resident received Furosemide oral tablet 40 mg one tablet daily. The medication was documented as administered, but SBP was documented only on 04/09/25. Record review of R145's February 2025 MAR in the EMR revealed resident received Losartan Potassium oral tablet daily. The medication was documented as administered, but SBP was not documented each day prior to administration. Record review of R145's March 2025 MAR in the EMR revealed resident received Losartan Potassium oral tablet daily. The medication was documented as administered, but SBP was not documented each day prior to administration. Record review of R145's April 2025 MAR in the EMR, revealed resident received Losartan Potassium oral tablet daily. The medication was documented as administered, but SBP was documented only on 04/09/25. Record review of R145's February 2025 MAR in the EMR, revealed resident received Carvedilol oral tablet 3.125 mg. Give one tablet by mouth two times a day for congestive heart failure at 9:00 AM and 8:00 PM. Hold for SBP less than 100 or heart rate less than 50. The medication was documented as administered, but SBP nor heart rate was not documented each day prior to administration. Record review of R145's March 2025 MAR in the EMR, revealed resident received Carvedilol oral tablet 3.125 mg. Give one tablet by mouth two times a day. The medication was documented as administered, but SBP nor heart rate was not documented each day prior to administration. Record review of R145's April 2025 MAR in the EMR, revealed resident received Carvedilol oral tablet 3.125 mg. Give one tablet by mouth two times a day. The medication was documented as administered, but the SBP and heart rate was documented only on 04/09/25. Record review of R145's February, March, April 2025 Blood Pressure Summary revealed the resident received blood pressure monitoring on infrequent days and infrequent times, not documented in collaboration with the administration of the identified medications that required parameter monitoring, nor noted in the MARs. During an interview on 04/10/25 at 12:04 PM, Registered Nurse (RN)4 stated that she completed vitals prior to the administration of medications. She stated that for R145 if the resident's systolic (blood pressure) was below 100 or his pulse was low, she would hold his blood pressure medications. RN4 said that if a resident's vitals were below parameters, you would hold the medication and would document that in the EMR and would be required to document in the progress note. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/10/25 at 3:35 PM, Licensed Practical Nurse/Unit Manager (LPN) 15 stated that when a resident was on skilled care, they would have their vitals done daily. She confirmed that they might not all be documented in the EMR. LPN15 said that if a resident had parameters for some medications, she would expect to see those vitals taken, and if they were outside the correct levels, the medication should not be given. She confirmed there should be a progress note, as well. Upon review of R145's MAR she confirmed that R145 had not had all vitals taken prior to the administration of medications that required parameter monitoring. During an interview on 04/10/25 at 4:58 PM, the Director of Nursing (DON) stated that she was not sure why the physician order to discontinue vitals was discontinued on 03/01/25 for R145. She stated she would expect to see medication orders followed to ensure medications were given according to the parameters. Upon review of R145'sMARshe confirmed the resident did not have regular vital checks prior to the administration of these medications. She stated she would expect the parameters to be followed.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 32513 Based on observations, interviews, record review, and review of facility policy, the facility failed to maintain a medication error rate of less than 5% when two oral medications were not administered according to the physician's order for two (Residents (R)20 and R80) of seven residents observed during medication pass. This consisted of two medications errors in 30 opportunities for a 6.67% error rate. Findings included. Review of the facility's policy titled, Administering Oral Medications dated 2001 revealed, .Medications are administered in accordance with prescriber orders, including any required time frame .The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) before giving the medication . 1. During a medication pass observation on 04/10/25 at 8:39 AM. Licensed Practical Nurse (LPN) 8removed a multivitamin (MVI) with iron tablet from a bottle in the top drawer of the medication and placed the medication into the medication cup. In addition, there was one Ferrous Sulfate (Iron replacement medication) 325milligram (mg) tablet which had been placed into the medication cup earlier. Review of the April Medication Administration Record (MAR) located in the Orders tab of the electronic medical record (EMR) revealed, Multi-Vitamin/Minerals. Give one tablet by mouth one time a day for dietary supplement. Start Date 07/28/23. Review of the April MAR located in the Orders tab of EMR revealed, Ferrous Sulfate 325mg. Give one tablet by mouth one time a day related to IRON DEFICIENCY. Start Date, 03/13/19. During an interview on 04/10/25 at 8:40 AM, LPN 8 was asked if the physician had been notified that R20 was receiving both an iron replacement and a MVI with iron. LPN 8 stated, This was the bottle on the medication cart. LPN 8 acknowledged that R20 may have been given too much iron. 2. During a medication pass observation on 04/10/25 at 8:54 AM, LPN 1 removed a Vitamin D 10 mcg [micrograms] (400 IU-International Units) one tablet and placed it into the medication cup with R80's other morning medications and then administered them to R80. Review of the MAR located in the Orders tab of the EMR revealed, Vitamin D 100 mcg (4000 IU). Give one tablet by mouth one time a day for supplement. Dated 06/05/24. During an interview on 04/10/24 at 10:15 AM, LPN 1 was asked why the 10 mcg Vitamin D was administered instead of the 100 mcg Vitamin D. LPN1 looked through the top drawer of the medication cart and could not find a bottle of Vitamin D 100 mcgs. LPN 1 then went to the medication room and found a bottle of D3 (Vitamin D) which was labeled 50 mcg (2000 IU) and stated, I should have given two of these to equal the 100 mcg (4000 IU) per the physician order. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/10/25 at 1:15 PM, the Director of Nursing (DON) was told about the 6.67% medication error rate and the two medication errors in 30 opportunities. The DON acknowledged that these were medication errors.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 32513 Based on interviews, document review, and review of the facility policy, the facility failed to ensure narcotic counts were initialed by the on-coming nurse (7:00AM to 7:00PM) and the off-going nurse (7:00PM to 7:00AM) at the change of shift to ensure the narcotic count was accurate for eight of eight medications carts reviewed. This failure had the potential for drug diversion. Findings included. Review of the facility's policy titled, Controlled Substances dated 2001 revealed, .Nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory count . The nurse coming on duty and nurse going off duty make the count together and document and report any discrepancies to the director of nursing services . 1. Review of the medication cart identified as 100 hall-cart 1 on 04/09/25 at 9:23 AM with Licensed Practical Nurse (LPN) 4 revealed on 04/07/25 the on-coming and off-going nurse did not identify how many narcotic cards were in the narcotic box at the end of the shift. In addition, on 04/08/25 the off-going nurse did not initial that the narcotic count was correct or document how many narcotic cards were in the narcotic drawer at the end of the shift, as required on their narcotic sheet, as required on the narcotic sheet. 2. Review of the medication cart identified as 100 hall-cart 2 on 04/09/25 at 9:36 AM with LPN 6 revealed on 04/05/25 and 04/06/25 the off-going nurse did not initial the narcotic was correct. On 04/07/25 the on-coming nurse did not document how many narcotic cards were in the narcotic box and on 04/09/25 the on-coming nurse did not initial that the narcotic count had occurred or how many narcotic cards were in the narcotic box, as required on the narcotic sheet. 3. Review of the medication cart identified as 200 hall-cart 1 on 04/09/25 at 9:42 AM with LPN 11 revealed on 04/02/25 there were no initials that the on-coming nurse had counted the narcotics with the off-going nurse, as required. 4. Review of the medication cart identified as 200 hall-cart 2 on 04/09/25 at 9:46 AM with LPN 8 revealed on 04/03/25 there were no initials that the on-coming nurse or the off-coming nurse had counted the narcotics, as required. 5. Review of the medication cart identified as 300 hall-cart 1 on 04/09/25 at 9:50 AM with LPN 12 revealed no documentation to show the on-coming nurse had initialed that there was a narcotic count was done with the off-going nurse. During an interview on 04/09/25 at 9:52 AM, LPN12 stated, That was a mistake as I don't usually work this shift. LPN 12 further stated, I did not realize I had done this. (continued on next page)

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	04/10/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. Review of the medication cart identified as 300 hall-cart 2 on 04/09/25 at 10:44 AM with Registered Nurse (RN) 1 revealed on 04/04/25 the number of narcotic cards in the narcotic drawer was not documented for the start of the shift and at the end of the shift. In addition, on 04/07/25 the off-going nurse did not initial the narcotic count as being correct. 7. Review of the medication cart identified as 400 hall-cart 1 on 04/09/25 at 10:56 with LPN 3 revealed, there was no documentation at the end of shift to show how many narcotic cards were in the narcotic drawer. On 04/02/25 the end of shift documentation did not show the number of narcotic cards that were in drawer, despite having documentation to show three cards were removed during the shift. On 04/03/25 there were no initials to indicate the start of the shift, and the end of shift narcotic count was performed. 8. Review of the medication cart identified as 400 hall-cart 2 on 04/09/25 at 11:09 AM with LPN 3 revealed on 04/01/25, 04/02/25, 04/04/25, 04/05/25, 04/07/25 and 04/08/25 the end of shift nurse did not document the number of narcotic cards that were in the drawer, per the narcotic sheet. In addition, the on-coming nurse on 04/09/25 did not initial that the narcotic count was performed. Interview on 04/09/25 at 11:10:00 AM, when LPN3 was asked why she did not document that a narcotic count was performed, she did not answer. During an interview on 04/09/25 at 11:24 AM, the Director of Nursing (DON) was shown the blanks in documentation. The DON confirmed that the narcotic sheets contained blanks and stated, The staff are to count the meds and in addition, to document their initials at the start of the shift and at the end of the shift.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36190 Based on observation, interview, record review, document review and policy review, the facility failed to have menu spreadsheets and/or follow menu spreadsheets for portion sizes for three (Resident (R)51, R61 and R92) of three residents reviewed for menus and therapeutic diets for 81 residents reviewed for menus. This deficient practice could cause residents to choke on food and/or lose weight. Findings include: Review of the facility's policy titled Menus dated 2001 revealed, 1. Menus meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board (National Research Council and National Academy of Sciences). 2. Menus for regular and therapeutic diets are written at least two (2) weeks in advance and are dated and posted in the kitchen at least one (1) week in advance. Review of the facility's diet roster dated 04/10/25 located in the EMR under the Report tab revealed 37 residents were prescribed a mechanical soft diet, 14 residents were prescribed a pureed diet, 42 residents were prescribed a CCHO [carbohydrate-controlled] diet, and eight were prescribed a renal diet. Review of the facility's spreadsheets for the 2024 Menus for the week of 04/07/25 through 04/13/25 revealed diets were planned for regular, pureed, mechanical soft ground, CCD and Renal. Review of the facility's Week 4 general menu dated 04/06/25 through 04/12/25 provided by the facility did not match the 2024 Menu spreadsheets and did not include therapeutic diets or portion sizes. 1. Observation of the tray line on 04/08/25 at 4:43 PM, the Kitchen Manager (KM) pointed to the Week 4 general menu posted in the kitchen that included Asian Stir Fry (chicken), egg roll, rice, mixed vegetables, and a cookie. Dietary Aide (DA) plated the pureed chicken, pureed baked beans, pureed green beans, regular textured green beans, regular textured mixed vegetables, ground chicken, and chopped chicken using a blue long handled serving utensil. During an interview on 04/09/25 at 4:27 PM, the KM confirmed the blue long handle serving spoon was two ounces and there was no menu spreadsheets for the Asian Stir Fry meal on 04/08/25 at supper. The KM then reviewed another similar menu spreadsheets and stated four ounces should have been served for the above menu items. 2. Review of R61's significant change Minimum Data Set (MDS,) with an Assessment Reference Date (ARD) date of 02/25/25 located in the MDS tab of the Electronic Medical Record (EMR) revealed an admitted [DATE], a Brief Interview for Mental Status (BIMS) of 00, indicating he was cognitively impaired, received a mechanically altered diet and therapeutic diet, and had diagnosis of dysphagia following cerebral infarction, hemiplegia or hemiparesis, and chronic kidney disease. Review of R61's diet order dated 10/22/24 located in the EMR under the Order tab revealed Liberal Renal, Large Portions diet, Pureed texture, Thin Liquids consistency. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/09/25 at 8:27 AM, R61 was served his breakfast tray that included a large portion of pureed eggs, pureed hot cereal, and pureed sausage. Review of the general breakfast menu used for 04/09/25 revealed Baked Cheesy Omelet, English muffin, strawberry yogurt, bacon or sausage, and cold cereal. The breakfast menu did not include a menu for a pureed textured diet or a renal diet. On 04/09/25 at 1:32 PM, R61 was served his lunch tray. Certified Nurse Aide (CNA)3 confirmed the meal included a large portion of pureed meat, apple sauce, tea, peas, and mashed potatoes. Review of the general lunch menu used by dietary for the 04/09/25 lunch meal revealed country fried steak, mashed potatoes, peas, Hamburger steak renal, noodles , warm apples. The lunch menu did not include a menu for a pureed textured diet. 3. Review of R51's annual MDS with an ARD date of 03/01/25 located in the MDS tab of the EMR revealed an admitted [DATE], a BIMS score of five out of 15 which indicated R51 was cognitively impaired, received a mechanically altered diet and therapeutic diet, and had diagnosis of non-Alzheimer's dementia, and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. Review of R51's diet order dated 06/17/24 located in the EMR under the Order tab revealed, NAS [No Added Salt] diet, Mechanical Soft Chopped texture, Thin Liquids consistency. On 04/09/25 at 1:21 PM, R51 was served his lunch tray that included ground country fried steak, peas, mashed potatoes, baked apples, and milk. Review of the general lunch menu used for 04/09/25 revealed, country fried steak, mashed potatoes, peas, and warm apples. The lunch menu did not include a menu for a mechanically altered texture diet. 4. Review of R92's annual MDS with an ARD date of 02/10/25 located in the MDS tab of the EMR revealed an admitted [DATE], a BIMS score of 15 out of 15, indicating he was cognitively intact, received a therapeutic diet, and had diagnosis of obesity due to excess calories. Review of R92's diet order, dated 12/19/24 located in the EMR under the Order tab revealed, CCHO, NAS diet, Regular texture, On 04/09/25 at 1:00 PM, R92 was served his lunch tray that included a country fried steak, mashed potatoes, a roll, peas, a beverage, and no dessert. Review of the general lunch menu used for 04/09/25 revealed, country fried steak, mashed potatoes, peas, and warm apples. The lunch menu did not include a menu for a CCHO diet. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/08/25 at 6:30 PM, the Registered Dietitian (RD) was asked why the Week 4 general menus for 4/7/25-4/13/25 didn't match the 2024 menu spreadsheets for 04/08/25-4/13/25. The RD stated the facility was changing over to new menus and they are still discussing if they should develop their own or use another company. The RD stated the spreadsheets for the 04/06-12/25 menus were still being developed and the general menus have been in use for about one month. The RD stated that for lunch and dinner on 04/08/25, she approved a substitution. The RD provided the substitution list for lunch on 04/08/25 which reflected a lunch entree, BBQ chicken was substituted for turkey and dinner on 04/08/25 fried sweet and sour chicken was substituted for deli sandwiches. The RD was asked about the substitution for the side dishes these two meals and RD confirmed the list didn't include side dishes. During an interview on 04/09/25 at 4:27 PM, the RD and KM were asked if the spreadsheets haven't been developed for the diets how does dietary know what portions to serve. The RD stated it's based on the old menu portions, and they are mixed and matched with recipes. The KM was asked how dietary knew what foods to puree as not all foods puree and did the pureed diets get bread today at breakfast, 04/09/25. The KM stated, No, not sure. The KM checked and confirmed an English muffin should have been provided. The KM was asked if there are no spreadsheets to follow for 04/09/25 lunch, what foods should be served for the therapeutic diets such as mechanical soft, renal or CCHO for R51, R61, and R92. The KM stated they were using old menus as a reference. During a follow-up interview on 04/10/25 at 8:07 AM, the KM was asked for the lunch menus used for the country fried steak, on 04/09/25 which wasn't included in the previous set of spreadsheets provided. The KM stated he didn't have a menu to follow for country fried steak menu, but the RD approved it but didn't include the side dishes. The KM stated he used the Salisbury steak menu as a reference. When the Salisbury steak menu was reviewed, the menu included corn, green beans, dinner roll, and a chocolate brownie. The KM went on to say the breakfast menu always stayed the same for the most part. The KM reviewed an old breakfast pureed menu spreadsheet and confirmed a bread item should be provided but hadn't been. The KM stated he doesn't have spreadsheets for staff to follow for portion sizes, just does a pre meal set-up, telling his staff what serving size utensils to use. The KM stated he was currently working on new menus.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39540 Based on observation, interview, resident record, and facility policy, the facility failed to ensure residents receiving dialysis treatments had accurate documentation of care provided for the dialysis site for two of three residents (Resident (R) 113 and R412) reviewed for dialysis care. The deficient practice has the potential for the residents to not receive dialysis care in the facility. Findings include: 1. Review of R113's Admission Record located in the EMR under the Profile tab revealed an admitted [DATE] with medical diagnosis that included chronic kidney disease, stage three. Review of R113's physician orders under the Orders tab in the EMR documented an order dated 03/26/25 indicating, Resident has arteriovenous (AV) fistula (shunt) located on [right]chest wall. Monitor for presence of bruit (auscultation) and thrill (palpation of vibration) [every] shift. Notify MD [Medical Doctor] if unable to auscultate of palpate. Monitor [each] shift for bleeding. Drainage, excessive warmth, pain, redness, numbness in fingers, tenderness, or swelling. Check circulation [each] shift by palpating distal pulses, observing capillary refill, assessing numbness, tingling, altered sensation, coldness, and pallor. Notify MD of abnormal findings, every shift document if bruit is present (+) absent (-) also document if thrill is present or absent. Review of R113's EMR Medication Administration Record (MAR) for March 2025 documented the presence on bruit and thrill on four shifts and the MAR for April documented the presence on bruit and thrill 17 shifts. During an interview on 04/10/25 at 6:20 PM, Registered Nurse (RN) 3 confirmed R113 had a central venous catheter (CVC) located on the right chest wall and secured with a dressing. RN3's practice was to check for redness, drainage, and intact dressing. There was no bruit or thrill to check for and when documenting there was no other place to document the condition of the CVC dressing. RN3 did confer with RN1 about the documentation confusion and did not inquire with the unit manager about the confusion in the documentation and decided to document what was available on the MAR even if it was not what was being done. During an interview on 04/10/25 at 6:40 PM, RN1 acknowledged knowing the difference between a CVC and arteriovenous (AV) fistula for dialysis access. RN1 confirmed R113 had a CVC for dialysis access. RN1 confirmed documenting presence of thrill and bruit for R113 and aware that assessment was not accurate. RN1 spoke to RN3 about the inaccurate documentation in the MAR and chose to mark in the MAR even though the assessment was for dressing being intact and dry. During an interview on 04/10/25 at 9:50 AM, LPN1/Unit Manager confirmed there was no AV fistula for documentation of thrill and bruit. 2. Review of R412's Admission Record located in the EMR under the Profile tab revealed an admitted [DATE] with a readmitted [DATE] with medical diagnosis that included end stage renal disease (ESRD) (continued on next page)

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	425146	A. Building B. Wing	04/10/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R412's physician orders under the Orders tab in the EMR documented an order dated 03/26/25 for Gentamicin Sulfate external ointment 0.1 percent (%). Apply to peritoneal dialysis (PD) catheter topically every evening shift. Use gauze to apply Q tip sized amount. Review of R412's EMRMAR for March 2025 documented the gentamicin applied to PD catheter on five evening shifts and the MAR for April 2025 documented the gentamicin applied to PD catheter on nine evening shifts During an interview on 04/08/25 at 2:00 PM, R412's family member (FM)1 explained that the resident went out for dialysis treatment because the PD catheter had been removed from the abdomen during the hospitalization prior to being admitted to the facility. During an interview on 04/09/25 at 1:40 PM, Licensed Practical Nurse (LPN)3 verified the order for gentamicin for R412 and confirmed the PD catheter had been removed. LPN3 verified the site was healed and no longer needed the order for gentamicin to be applied. LPN3 verbalized documentation of the application of gentamicin being applied was not correct documentation. During an interview on 04/10/25 at 11:00 AM, the Director of Nursing (DON) and the Infection Preventionist/Unit Manager (IP) both confirmed R113 had a CVC inserted in the right chest wall for dialysis access. Residents with CVC do not have a bruit or thrill present to be monitored. Monitoring needed was for dressing to be dry and clear, catheter secure. Documentation for presence of bruit and thrill for R113 was inaccurate, false documentation since with a CVC catheter the resident does not have a thrill or bruit. The DON and IP confirmed R412 did not have a peritoneal dialysis catheter and the order to apply gentamicin to the PD site on the abdomen was incorrect. Both confirmed the documentation about application of gentamicin to the PD catheter was inaccurate documentation.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39540 Based on observation, interview, record review, and facility policy review the facility failed to follow the facility's policy and ensure signage for Enhanced Barrier Protection (EBP) was posted for residents who had a urinary catheter, gastrostomy tube (G-tube), dialysis, and/or open wounds for 13 of 34 residents (Resident (R) R113, R412, R16, R151, R126, R88, R119, R75, R38. R10, R22, R114, and R101) reviewed for EBP. As a result of this deficient practice the staff had the potential to spread infections from one resident to another. Findings include: Review of the facility's policy titled Enhanced Barrier Precautions, revised 03/24, revealed EBP's are (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). b. Personal protective equipment (PPE) is charged before caring for another resident. c. Face protection may be used if there was also a risk of splash or spray. Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required. 1. Review of R113's Admission Record located in the EMR under the Profile tab revealed an admitted [DATE] with medical diagnosis that included chronic kidney disease, stage three. Review of R113's physician's orders in the EMR under the Orders tab confirmed an order for dialysis three times a week. Observation on 04/08/25 at 1:30 PM, the door for R113 lacked a sign for EBP indicating the personal protective equipment (PPE) to be applied for direct resident care. During an observation on 4/10/25 at 9:33 AM, Licensed Practical Nurse (LPN)13 confirmed the central venous catheter (CVC) catheter was located on the right chest wall by moving the resident's clothing to reveal the dressing. LPN13 was not wearing gloves at the time of the observation of the dressing. 2. Review of R412's Admission Record located in the EMR under the Profile tab revealed an admitted [DATE] with a readmitted [DATE] with medical diagnosis that included end stage renal disease (ESRD). Observation on 04/08/25 at 10:30 AM, the door lacked a sign for EBP indicating the PPE to be applied for direct resident care. Observation on 04/08/25 at 5:06 PM, Certified Nursing Assistant (CNA)1 came into the room for R412 for brief change, applied gloves, and did not apply any other personal protective equipment (PPE) prior to changing the brief. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of R16's Admission Record located in the EMR under the Profile tab revealed an admitted [DATE] with a readmitted [DATE] with medical diagnosis that included neuromuscular disfunction of the bladder. Review of R16'sphysician's orders revealed an order for a suprapubic urinary catheter. During a tour of 200 hallway on 04/10/25 at 7:50 AM, R16's room lacked a sign for EBP indicating the PPE to be worn when providing direct resident care. 4. Review of R151's Admission Record located in the EMR under the Profile tab revealed an admitted [DATE] with medical diagnosis that included gastroesophageal reflux disease. Review of R115'sphysician's order revealed an order for G-tube. Tour of the 100 hallway on 04/10/25 at 7:34 AM, R151's room lacked a sign for EBP indicating PPE to be worn when providing direct resident care. 5. Review of R126's Admission Record located in the EMR under the Profile tab, revealed an admitted [DATE] with medical diagnosis that included a pressure ulcer stage three. Review of R126'sphysician's orders revealed orders for wound care on right above knee amputation (AKA) wound and an order dated 03/16/25 for EBP for high contact resident care activities secondary to wound (care) every shift. Tour of the 400 hallway on 04/10/25 at 7:40 AM, R126's room lacked a sign for EBP indicating PPE to be worn when providing direct resident care. 6. Review of R88's Admission Record located in the EMR under the Profile tab revealed an admitted [DATE] with a readmitted [DATE] with medical diagnosis that included ESRD. Review of R88's physician's orders revealed orders for dialysis three times a week and EBP every shift. Tour of the 300 hallway on 04/10/25 at 7:30 AM, R151's room lacked a sign for EBP indicating PPE to be worn when providing direct resident care. 7. Review of R119's Admission Record located in the EMR under the Profile tab revealed an admitted [DATE] with a readmitted [DATE] with medical diagnosis that included neuromuscular dysfunction of the bladder. Review of R119's physician's orders revealed an order for suprapubic catheter and EBP for high contact resident care activities secondary to wound (care)and urinary catheter every shift. Tour of the 400 hallway on 04/10/25 at 7:40 AM, R119's room lacked a sign for EBP indicating PPE to be worn when providing direct resident care. (continued on next page)

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	425146	A. Building B. Wing	04/10/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. Review of R 75's Admission Record located in the EMR under the Profile tab revealed an admitted [DATE] with a readmitted [DATE] with medical diagnosis that included obstructive and reflux uropathy. Review of R75'sphysician's orders revealed an order for a indwelling urinary catheter and for EBP for high contact resident care activities secondary to urinary catheter every shift. Tour of the 300 hallway on 04/10/25 at 7:30 AM, R75's room lacked a sign for EBP indicating PPE to be worn when providing direct resident care. 9. Review of R38's Admission Record located in the EMR under the Profile tab revealed an admitted [DATE] with medical diagnosis that included dysphasia. Review of R38'sphysician's orders revealed orders for enteral feedings through a G-tube. Tour of the 400 hallway on 04/10/25 at 7:40 AM, R38's room lacked a sign for EBP indicating PPE to be worn when providing direct resident care. 10. Review of R10's Admission Record located in the EMR under the Profile tab revealed an admitted [DATE] with a readmitted [DATE] with medical diagnosis that included ESRD. Review of R110'sphysician's orders for dialysis three days a week and an order dated 03/19/25 for EBP related to dialysis. Tour of the 400 hallway on 04/10/25 at 7:40 AM, R10's room lacked a sign for EBP indicating PPE to be worn when providing direct resident care. 11. Review of R22's Admission Record located in the EMR under the Profile tab revealed an admitted [DATE] with medical diagnoses that included benign prostatic hyperplasia and indwelling catheter complications. Review of R22'sphysician's orders revealed orders for a urinary catheter. Tour of the 100 hallway on 04/10/25 at 7:45 AM, R22's room lacked a sign for EBP indicating PPE to be worn when providing direct resident care. 12. Review of R114's Admission Record located in the EMR under the Profile tab revealed an admitted [DATE] with medical diagnosis that included dementia. Review of R114's physician's orders revealed orders for wound care on both heels. Tour of the 300 hallway on 04/10/25 at 7:30 AM, R114's room lacked a sign for EBP indicating PPE to be worn when providing direct resident care. 13. Review of R101's Admission Record located in the EMR under the Profile tab revealed an admitted [DATE] with medical diagnosis that included neuromuscular dysfunction of the bladder. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R101'sphysician's orders revealed orders for a suprapubic catheter and EBP for high contact resident care activities secondary to suprapubic catheter care every shift. Tour of the 200 hallway on 04/10/25 at 7:50 AM, R101's room lacked a sign for EBP indicating PPE to be worn when providing direct resident care. During an interview on 04/10/25 at 11:00 AM, the Director of Nursing (DON) and the Infection Preventionist/Unit Manager (IP) both confirmed residents for dialysis, with wound care, with urinary catheters and with G-tubes were to be on EBP indicating staff were to be wearing gown and gloves during direct resident contact.

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	04/10/2025

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39540 Based on interview, record review, review of the Centers for Disease Control and Prevention (CDC) recommendation pneumococcal vaccination for all adults [AGE] years or older, and facility policy review, the facility failed to offer pneumovax recommended updates for five of five residents (Residents (R)49, R39, R86, R53, and R83) reviewed for pneumonia vaccinations out of a total sample of 34 residents, the opportunity for the resident to be vaccinated in accordance with nationally recognized standards. This practice had the potential to increase the risk for these residents to contract pneumonia. Findings include: Review of the facility's policy titled Pneumococcal Vaccine dated 10/19 indicated, All residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. Administration of the pneumococcal vaccines or revaccinations will be made in accordance with current CDC recommendations at the time of the vaccination. Review of CDC recommendation pneumococcal vaccination for all adults [AGE] years or older revealed: Not previously received a dose of PCV13, PCV15, or PCV20 or whose previous vaccination history is unknown: l dose PCV15 or 1 dose PCV20. If PCVl5 is used, this should be followed by a dose of PPSV23 given at least 1-year after the PCV15 dose. Review of R49's Admission Record located in the electronic medical record (EMR) under the Profile tab revealed an admitted [DATE]. The resident was over the age of 65 at the time of admission. Review of R49's Immun tab for immunizations located in the EMR indicated the resident received Pneumococcal polysaccharide vaccine (PPSV23) on 04/11/22. The facility failed to offer one dose of Pneumococcal 15-valent Conjugate Vaccine (PCV15) or one dose of Prevnar 20 (PCV20) or PCV21 at least one year after last dose of PPSV23. Review of R39's Admission Record EMR under the Profile tab revealed an admitted [DATE]. The resident was over the age of 65 at the time of admission. Review of R39's Immun tab for immunizations located in the EMR indicated the resident received PPSV23 on 11/08/19. The facility failed to offer one dose PCV15 or one dose of PCV20 or PCV21 at least one year after last dose of PPSV23. Review of R86's Admission Record EMR under the Profile tab, revealed an admitted [DATE]. The resident was over the age of 65 at the time of admission. Review of R86's Immun tab for immunizations located in the EMR indicated the resident received PVC13 on 10/29/15. The facility failed to offer one dose of PCV20 or PCV21 at least one year after the last dose of PCV13. Review of R53's Admission Record EMR under the Profile tab, revealed an admitted [DATE] and readmitted on [DATE]. The resident was over the age of 65 at the time of admission. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R53's Immun tab for immunizations located in the EMR indicated the resident received PVC13 on 01/30/18. The facility failed to offer one dose of PCV20 or PCV21 at least one year after the last dose of PCV13. Review of R83's Admission Record EMR under the Profile tab, revealed an admitted [DATE]. The resident was over the age of 65 at the time of admission. Review of R83's Immun tab for immunizations located in the EMR indicated the resident refused pneumovax vaccinations in the past. The facility failed to offer one dose of PCV15, PCV20, or PCV21. During an interview on 04/09/25 at 4:14 PM, the Regional Director of Clinical Services (RDCS) explained the facility did not follow up on the pneumovax and it was the expectation if the pneumovax update was to be given, the provider would order it. During an interview on 04/10/25 at 4:50PM, the Infection Preventionist (IP) verbalized that the facility did not follow up with the residents about the pneumovax update. During the admission process the residents would be asked if they wanted an updated pneumovax and confirmed the admission person would not know if it was recommended by CDC or not.