STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425129	A. Building B. Wing	07/17/2025

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St Andrews Operator, LLC	3514 Sidney Road Columbia, SC 29210

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. (continued on next page)

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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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, record review and interviews, the facility failed to ensure resident assessments accurately reflected the resident's status for pressure ulcers for 1 of 2 residents, Resident (R)10, reviewed for pressure ulcers. Specifically, R10 was readmitted to the facility on [DATE] with a sacral pressure ulcer that was not documented on his skin assessment or Minimum Data Set (MDS). Findings include:Review of the facility policy titled Resident Assessments last revised on 03/22 revealed, 1. The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments and reviews.Review of the facility policy titled Functional Impairment - Clinical Protocol last revised 03/18 revealed, Upon admission to the facility, whenever a significant change of condition occurs, and periodically during a resident/patient's stay, the physician and staff will assess the resident/patient's function along with their physical condition.Review of R10's Face Sheet revealed he was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including but not limited to malignant neoplasm of lateral wall of the bladder, malignant neoplasm of left kidney, hemiplegia and hemiparesis, acute cystitis with hematuria and diabetes mellitus type two. R10's sacral pressure ulcer was not listed. Review of R10's re-admission Head to Toe Skin Check dated 06/21/25 revealed, Skin Integrity, New Other Issue, Resident returned from hospital with new open area to coccyx, noted under type as pressure no further documentation of the wound was noted.Review of R10's Weekly Head to Toe Skin Check dated 06/28/25 noted R10's skin to be intact with no documentation of any wounds. Review of R10's Weekly Head to Toe Skin Check dated 07/05/25 revealed, Skin Integrity, Existing Pressure Ulcer, open area noted to sacrum. No additional wounds documentation was noted. Review of R10's Weekly Head to Toe Skin Check dated 07/12/25 revealed, Skin Integrity, New Pressure Ulcer, Sacrum Wound, Under wound care DR.Review of a document titled Provider Communication Log revealed, on 06/21/25, R10 had a concern noted as New open area to coccyx, 9.5 [centimeters] cm [by] x 10.3 cm, Wound [doctor] DR aware. Review of R10's Physician Orders revealed Apply Santyl and Alginate to sacrum wound bed. Cover with border dressing. every shift for Wound Care with a start date of 07/02/25. Review of R10's Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/30/25 revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating R10 was cognitively intact. Review of Section M - Skin Conditions noted R10 was at risk of pressure ulcers but did not have any pressure ulcers. During an interview on 07/16/25 at 4:35 PM, Licensed Practical Nurse (LPN) 3 stated the facility does not have a dedicated wound care nurse. LPN3 stated the facility nurses perform wound care and assessments. The wound care provider and the Nurse Practitioner (NP) make weekly rounds at the facility to assess residents with wounds.During an interview on 07/17/25 at 8:40 AM, the MDS Coordinator stated that she is responsible for completing MDS assessments. She then stated that she uses the assessments/evaluations completed by the nursing staff and placed in the Electronic Medical Record (EMR) to complete the necessary MDS. The MDS Coordinator also noted that when completing a Significant Change in Status MDS for R10, she did a seven-day lookback at his skin assessment, and it showed that his skin was intact. The MDS Coordinator confirmed that R10 did indeed have a sacral pressure ulcer that was not accurately documented in the resident skin/wound assessments. During an interview on 07/17/25 at 8:54 AM, the Director of Nursing (DON) stated the Unit Managers (UM) on the floor are responsible for completing admission assessments for the residents; however, the floor nurses complete ongoing skin assessments and should notate if there are any skin issues. The DON also stated she expects assessments to be complete and accurate.

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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** Based on interview, record review, and facility policy review, the facility failed to timely develop a baseline care plan for 1 (Resident (R)502) of 7 sampled residents.Findings include:Review of an undated facility policy titled Care Plans-Baseline revealed, A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission.Review of an admission Record revealed the facility admitted R502 on 07/16/25. According to the admission Record, the resident had a medical history that included but was not limited to diagnoses of cerebral infarction, hyperglycemia, aphasia, and gastrostomy status.Review of R502's medical record revealed a care plan report for an admission date of 07/16/25. The care plan report initiated on 08/06/25 indicated the resident was admitted to the facility with pressure areas to several areas of their body and non-pressure areas to the back and left ear.During an interview on 08/23/25 at 3:30 PM, the Minimum Data Set (MDS) Coordinator stated R502's baseline care plan was not completed for the resident's admission on [DATE] until 08/06/25, and it did not include the resident's need to be fed by way of a tube. The MDS Coordinator stated the baseline care plan should include all interventions the resident needed so the staff could manage the resident's care until completion of the comprehensive care plan.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, record review, observations and interviews, the facility failed to ensure a resident with continuous tube feed received the correct ordered amount and rate of tube feed. The facility also failed to label and date a tube feed bag for 1 of 1 resident, Resident (R)9 reviewed for tube feedings. Specifically, R9's tube feed was infusing at 45 milliliters (ml) per hour (hr) instead of the physician's ordered rate of 50 ml per hour.Review of the facility policy titled Enteral Tube Feeding via Continuous Pump last revised on 11/18, states, The purpose of this procedure is to provide a guideline for the use of a pump for enteral feedings. General Guidelines. 3. Check the enteral nutrition label against the order before administration. Check the following information: Resident name, ID and room number; Type of formula; Date and time formula was prepared; and Rate of administration mL/hour. Initiate Feeding. On the formula label document initials, date and time the formula was hung/administered, and initial that the label was checked against the order.Review of R9's Face Sheet revealed R9 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including but not limited to: gastrostomy status, dysphagia and adult failure to thrive. Review of R9's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/07/25 revealed a Brief Interview for Mental Status (BIMS) score was unable to be conducted. Review of Section K - Swallowing/Nutritional Status noted R9 received 51% or more of nutritional intake through a Feeding Tube. Review of R9's Physician Orders documented the following: Order Date, 05/03/25: Enteral Feed Order two times a day related to Gastrostomy status. Jevity 1.5 at 50 mL/hr x 20 hours. 1000 mL total infused. Order Date, 05/19/25: Start Jevity 1.5 @ 50 ml at 8 pm. at bedtime start Jevity 1.5 @ 50 ml total feed 1000 ml. Order Date, 05/03/25: Turn feeding off at 4pm daily in the afternoon turn feeding off at 4pm daily.Review of a Nutrition Progress Note dated 07/10/25 revealed, Enteral: Jevity 1.5 at 50 mL x 20 hours, total infused 1000 mL. Run 8pm-4pm. This will provide 1500 [kilocalories] kcals, 63 [grams] gm [protein] PRO, and 750 mL of free water. Flush 250 mL [four times a day] QID (+1000 mL) = 1750 mL.During an observation on 07/16/25 at 9:59 AM, R9's tube feed was observed without a label or date, the feed was running at a rate of 45 ml/hr. During an observation on 07/16/25 at 11:58 AM, R9's tube feed was again observed at a rate of 45 ml/hr. During an interview on 07/16/25 at 12:06 PM, Licensed Practical Nurse (LPN)1, confirmed R9's tube feed orders of 50 ml/hr, and when notified that R9's current rate was not the ordered rate, LPN1 stated, Let me guess, it's at 45. LPN1 was asked if she verified the correct rate with the off-going nurse, LPN1 replied, She just told me she started it, no verification was done. LPN1 then entered R9's room and confirmed the incorrect rate of 45 ml/hr.During an interview on 07/17/25 at 8:54 AM, the Director of Nursing (DON) stated, the off-going nurse and the incoming nurse must verify and check residents' tube feed orders during change of shift, residents should receive tube feed as ordered.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, record review, observation, and interview, the facility failed to provide respiratory care in accordance with professional standards. Specifically, the facility failed to ensure one nebulizer machine, one oxygen mask and one medication chamber were clean and/or bagged when not in use for 1 of 2 residents (Resident (R)82), reviewed for respiratory care.Findings include:Review of the facility's policy titled Nebulizer Therapy, with a revision date of October 2024, revealed, Purpose: The purpose of this procedure is to safely administer aerosolized particles of medication into the resident's airway. Steps in the Procedure: 1. Obtain equipment (i.e., administration set up, plastic bag, gauze sponge). 2. Wash hands. 3. After completion of therapy: a. Remove the nebulizer container; b. Rinse the container with fresh tap water; and c. Dry on a clean paper towel or gauze sponge. 4. Reconnect to the administration setup when air dried. 5. Take care not to contaminate internal nebulizer tubes. 6. Wipe the mouthpiece with a damp paper towel or gauze sponge. 7. Store the circuit in a plastic bag, marked with the date and resident's name, between uses. 8. Wash hands. 9. Discard the administration set up every seven days. Review of the facility's policy titled Oxygen Administration, revision date of 01/23/25, revealed, Policy: Licensed clinicians with the demonstrated competence will administer oxygen via the specified route as ordered by a provider. In an emergency situation, clinicians may administer oxygen and obtain a provider's order as soon as practicably possible after patient stabilization or transfer. Procedure: 1. Verify provider order. Administration Via Nasal Cannula: 5. Set flow rate as prescribed or to obtain desired SpO2. Standard nasal cannulas provide flow rates up to 6L/min. >6L/min use high flow nasal cannula device.Review of R82's Face Sheet, located in the Electronic Medical Record (EMR) under the Clinical tab, revealed R82 was admitted to the facility on [DATE] with diagnoses including but not limited to metabolic encephalopathy, Chronic Obstructive Pulmonary Disease (COPD), respiratory failure, pneumonia and dementia. Review of R82's Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/03/25 revealed a Brief Interview for Mental Status (BIMS) score of 11 out of 15, indicating R82 has moderate cognitive impairment. Review of R82's Care Plan documented a focus: has oxygen therapy to relieve hypoxia r/t End Stage COPD, recent Flu, Hypoxia, respiratory distress, Chronic Hypoxemic respiratory failure. The goal documented, Will have no s/sx of poor oxygen absorption through the review date. Intervention directed staff to OXYGEN SETTINGS: O2 via nasal cannula as ordered.Review of R82's Medication Administration Record (MAR) for 07/01/25 - 07/17/25 revealed an order for O2 AT 2L-3L Continuous VIA NC every shift for to relieve hypoxia related to Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation; Acute and Chronic Respiratory Failure with an order date of 07/10/25. Review of R82's Physician Orders located in the EMR under the Orders tab and dated start date 07/10/25 with a revision date of 07/15/25 revealed an order for Budesonide Inhalation Susp 0.5 MG/2ML 2 cc inhale orally two times a day related to Acute and Chronic Respiratory Failure and Pneumonia, Pulmicort Suspension 0.5 MG/2ML (Budesonide) 2 ml inhale orally via nebulizer every 12 hours related to Chronic Obstructive Pulmonary Disease. Further review of the Physician Orders revealed O2 AT 2L-3L Continuous VIA NC every shift to relieve hypoxia related to Chronic Obstructive Pulmonary Disease with Acute Exacerbation and Acute and Chronic Respiratory Failure . with a start date of 07/11/25.During an observation and interview on 07/15/25 at 11:25 AM, R82's nebulizer mask lying in the middle of the resident's bed face down. The oxygen mask was attached to the medication chamber and the tubing. The mask was not bagged. There was a clear liquid in the medication chamber. The medication chamber was attached to the mask and the oxygen tubing. The medication chamber was not bagged. R82 states she does not know how much oxygen she is on. Further observation revealed oxygen noted running via concentrator. Nasal cannula noted in the resident's nose, and the oxygen rate was at 4 litres per minute (LPM).During an observation on 07/15/25 at 4:00 PM, revealed resident was sitting on the side of her bed, the oxygen concentrator was set at 4.0 liters per minute (LPM). The nebulizer was on the resident's bedside table. Black writing on the nebulizer mask reads 07/14/25. The oxygen mask was face down in the middle of the resident's bed. The mask was attached to the medication chamber and the tubing. The mask was not bagged. There was a clear liquid in the medication chamber. The medication chamber was attached to the mask and the oxygen tubing. The medication chamber was not bagged.During an interview on 07/15/25 at 4:10 PM, LPN1 verified the nebulizer mask was face down in the middle of the resident's bed. The mask was attached to the medication chamber and the tubing. The mask was not bagged. There was a clear liquid in

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on review of the facility policy, observations, record review and interviews, the facility failed to remove expired and discontinued medications from storage and failed to label and date open medications in 3 of 6 medication carts. Findings include:Review of the facility policy titled Medication Labeling and Storage last revised on 02/23 revealed the nursing staff is responsible for maintaining medication storage and preparation in a sanitary manner. If the facility has discontinued, outdated or deteriorated medications or biologic pharmacy is contacted for instructions regarding returning or destroying these items. Labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices. The medication label includes, at a minimum: expiration date, when applicable.On 07/16/25 at 11:38 AM, observation of the 200 Back Hall medication cart with Licensed Practical Nurse (LPN)4 revealed one box of Nutren 2.0 tube feeding formula with an expiration date of 06/27/25; one opened Novolog FlexPen injector with no open or expiration date; and one unidentified loose oblong white pill. LPN4 confirmed the findings and stated that the nurse who opened the insulin pen should have documented the open and expiration dates. She also explained that Novolog pens are typically only viable for 28 days after opening. LPN4 then disposed of the tube feeding formula and the loose pill.On 07/16/25 at 4:28 PM, observation of the 300 Hall medication cart with LPN3 revealed one opened bottle of Sorbitol 70% solution with an expiration date of 10/11/24 and one opened bottle of Robitussin DM with an expiration date of 11/29/24. LPN3 confirmed the medications were expired and stated they had been previously discontinued. However, she was unsure how to properly dispose of the medications and stated she would need to check with someone for that.During an interview on 07/17/25 at 8:46 AM, the Director of Nursing (DON) stated that all nurses have the authority to dispose of expired or discontinued medications on the medication carts using a [Drug Buster], which is kept on each cart. The DON further stated that Unit Managers are responsible for auditing the medication carts weekly, expired medications should be removed from medication carts.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and review of facility policy, the facility failed to ensure foods that are stored in the freezer, refrigerator and dry food storage were appropriately sealed, labeled, dated with a use by date, and/or discarded after the manufacturer's expiration date in 1 of 1 kitchen.Findings include:Review of the facility's undated policy, titled, Labeling and Dating, revealed Importance of Labeling and Dating Proper labeling and dating ensures that all foods are stored, rotated, and utilized in a First In First Out (FIFO) manner. This will minimize waste and ensure that items that are passed their due date are discarded. Food labels must include: The food item name, the date of preparation/receipt/removal from freezer, the use by date. Leftovers must be labeled and dated with the date they are prepared and the use by date.During an initial observation of the kitchen on 07/15/25 at 9:51 AM, the Dry Food Storage revealed the following:Boxes on the floor.1 - 10-pound (lb) bag of macaroni noodles was opened with no open date and no use-by date.1 - 25 lb box of semi-sweet mini morsels was opened and not sealed, with no open date and no use-by date.3 - 28 ounce (oz) diced tomatoes with green chiles with a use-by date of August 28, 2024.Multiple cans were covered with a white powdery substance.1 - 25 lb box of instant food thicker with an open not properly sealed, no open date, no use-by date,During an initial observation of the walk-in cooler/refrigerator, the following was revealed:Rusted shelves.1 - 8-quart (qt) container not labelled with food contents.1 - 1-gallon (gal) container of mayonnaise with no open date and no use-by date.1 - Cut onion wrapped with a prep date of 07/06/25 and a use-by date of 06/09/25.1 bag baby spinach was opened with no open date and no use-by date; the spinach was brown and wilted.During an initial observation, the walk-in freezer revealed the following:1 opened bag of frozen corn placed in a box that was labelled broccoli, not properly sealed, with no open date and no use-by date.1 30 lb box of cut green beans was opened and not sealed properly, with no open date and no use-by date.During a follow up observation of the kitchen on 07/17/25 at 11:45 AM, the bottom shelf of one prep table was lined with multiple sheets of aluminium foil. The following items were opened with no open date or use-by date and were being stored on this shelf:1 - 18 oz container of granulated onion.1 - 24 oz container of blackened seasoning.1 - 16 oz container of turmeric1 - 16 oz container of ground cinnamon.1 - 18 oz container of ground cinnamon.1 - 16 oz container of black pepper.1 - 16 oz container of Italian seasoning.1 - 42 oz container of Quick Oats marked with the following dates: 06/16/25, 06/20/25 and 06/25/25.1 - 5.3 lb container of mashed potatoes.During an interview on 07/17/25 at 8:57 AM, the Dietary Manager (DM) revealed that Healthcare Services took over the kitchen services in July 2024 and that he has been with the company for about 6 or 7 months. The DM states that his expectations for food storage are for items to be used first in/first out; any items that have been removed from it's original packaging should be rewrapped or repacked, sealed and labelled with a prep/open date and a use by date in the dry food storage, refrigerators and freezers. The DM states that any ready-to-eat food/leftovers should be discarded after 3 days. The DM explains that any items past the manufacturer expiration date or marked use by date should be discarded. The DM further explains that he conducts rounds/walks through the kitchen daily.During an interview on 07/17/25 at 3:51 PM, the Administrator revealed that the kitchen services are contracted out and managed by Healthcare services. The Administrator explains that he tries to conduct weekly or monthly walkthroughs of the kitchen. The Administrator explains that his expectation is that food items be stored with labels that include an open date, a use-by date or product manufacturer expiration date. The Administrator continues to explain that his expectation are that open items be in a container and sealed and that no food items be exposed.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on observation, interview, document review, and facility policy review, the facility's quality assurance and performance improvement (QAPI) committee failed to implement effective corrective actions to ensure previously identified deficient practices were corrected and sustained. This deficient practice had the potential to affect all 91 residents who resided in the facility.Cross Reference: F693, F761, and F812. Findings included:Review of a facility policy titled Quality Assurance and Performance Improvement (QAPI) Program Governance and Leadership Policy Statement, revised on 03/2020, revealed, 2. The governing body is responsible for ensuring that the QAPI program: a. Is implemented and maintained to address identified priorities; b. Is sustained through transitions of leadership and staffing; c. Is adequately resourced and funded, including the provision of money, time, equipment, training and staff coverage sufficient to conduct the activities of the program; d. Is based on data, resident and staff input, and other information that measures performance; and e. Focuses on problems and opportunities that reflect processes, functions and services provided to the residents.According to the Centers for Medicare & Medicaid Services (CMS) - 2567, during a Recertification and Complaint Survey conducted from 07/15/25 to 07/17/25, the facility was cited at F693 for a failure to label and date a tube feeding bag, F761 for a failure to label and date opened medications, and F812 for a failure to ensure food stored was sealed, labeled and dated with a use-by date. During observations conducted on 08/23/25, R502's tube feeding bag was not labeled; two medication carts had opened vials of insulin that were not labeled with an opened date; and food items in the kitchen were opened, unsealed and not labeled with an opened and/or use-by date. Review of the facility QAPI meeting minutes dated 08/15/25 revealed, Review of the Annual survey results. Discussion of the POC [plan of correction] and audit tools; see attached. The only reference to the plan of correction was a copy of the CMS-2567 attached to the meeting minutes.During an interview on 08/23/25 at 4:47 PM, the Administrator stated the QAPI committee discussed the plan of correction, and during the discussion, everyone reported the audits were effective. The Administrator stated he felt the audits were effective, and he did not understand why there were continued failures.

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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 - Many	Provide and implement an infection prevention and control program. F880Based on review of facility policy, observation, record review and interview, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically, the facility failed to produce documentation of a surveillance plan, based on a facility assessment, for tracking, and/monitoring infections, communicable diseases and outbreaks among residents and staff for the entire year 2024 and the months of January 2025 and February 2025.Findings include:Review of the facility policy titled Monitoring Compliance with Infection Control states, Policy Statement: Routine monitoring and surveillance of the workplace are conducted to determine compliance with infection prevention and control policies and practices.Policy Interpretation and Implementation: 1. The infection preventionist or designee monitors the compliance and effectiveness of our infection prevention and control policies and practices.2. Monitoring includes regular surveillance of adherence to hand hygiene practices and availability of hand hygiene supplies, and the availability of personal protective equipment and its appropriate use.3. The infection preventionist conducts compliance surveillance at least quarterly or at a frequency determined by the Infection Prevention and Control Committee (IPCC) or the Quality Assurance and Performance Improvement (QAPI) committee.4. Compliance surveillance is unannounced.5. Compliance surveillance includes the use of standardized assessment and observation tools.6. The infection preventionist and/or the IPC committee provides reports to the QAPI committee that reflect:Staff adherence to infection prevention processes (hand hygiene, use of personal protective equipment, etc.);Incidents of employee exposure to blood/body fluids (including a description of the precipitating events and outcomes);Adherence to the facility's antibiotic stewardship program; andAll infection surveillance data7. The QAPI committee reviews and acts upon, as necessary, surveillance and monitoring records.8. Gaps identified in infection prevention and control processes are addressed promptly.During an interview on 07/16/25 at 8:45 AM, the Infection Preventionist revealed, I identify infections by symptoms the resident is having. I talk to the doctor about the resident's symptoms. I talk to the doctor about drawing labs that could identify a potential infection. The doctor may order a broad-spectrum antibiotic if he chooses to cover the resident until the lab results are back. I complete the infection line tracking and any contact tracing. I have not needed to perform any contact tracing since I have been the infection preventionist.During an interview on 07/16/25 at 8:50 AM, the Director of Nursing (DON) revealed antibiotic stewardship is reviewed monthly in QAPI. During a follow-up interview on 07/17/25 at 11:20 AM, the Director of Nursing revealed the previous Assistant Director of Nursing (ADON) was also the infection preventionist. She left on March 3, 2025, and she took her infection control book with her. So there is no infection control data available before April 2025. We have a clinical meeting every morning, and we review all new antibiotics. The current ADON/ Infection Preventionist presents the number of Infections in QAPI each month. She has not presented any infection tracking in QAPI. During an interview on 07/17/25 at 1:30 PM, the Regional Clinical Nurse revealed all antibiotics are reviewed in the morning clinical meeting to make sure that we have an appropriate diagnosis and rationale. The line listing report is completed by the IP daily and the monthly infection rate report is completed monthly and presented in QAPI. There is no infection tracking or trending that I can produce before April 2025. The previous DON and ADON quit abruptly and took that information with them and we have not been able to get that information from them. We have made phone calls and sent letters with no response.