

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145457	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2025
NAME OF PROVIDER OR SUPPLIER Quincy Healthcare & Sr Living		STREET ADDRESS, CITY, STATE, ZIP CODE 1440 North 10th Street Quincy, IL 62301	

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)
<p>F 0550</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>38396</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident's call light was answered timely to provide toileting assistance for one of three residents (R1) reviewed for call lights in the sample of three. This failure resulted in R1 soiling herself while waiting for assistance and sitting for several hours and causing her emotional distress.</p> <p>Findings include:</p> <p>The facility's Resident Rights policy, dated 2/2021, documents Employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a dignified existence; be treated with respect, kindness, and dignity.</p> <p>The facility's Dignity policy, dated 2/2021, documents Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents; for example: promptly responding to a resident's request for toileting assistance.</p> <p>The facility's Resident's Call System policy, dated 9/2022, documents Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized work station. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor. Calls for assistance are answered as soon as possible, but no later than 5 minutes. Urgent requests for assistance are addressed immediately.</p> <p>R1's current electronic medical record documents R1 has diagnoses of Urinary Tract Infection, Chronic Diastolic (congestive) Heart Failure, Acute and Chronic Respiratory Failure, Morbid obesity and Chronic Kidney Disease stage 3.</p> <p>R1's current Care Plan, dated 4/24/25, documents (R1) will remain in homelike atmosphere at (the facility) and continue to have her needs met. (R1) will be continually monitored for safety and assisted so that her needs are met.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R1's Toileting assessment, dated 4/21/25, documents R1 requires assistance of one staff for toileting.</p> <p>R1's current Brief Interview for Mental Status assessment (BIMS), dated 4/7/25, documents R1 has a BIMS of 14 indicating R1 is cognitively intact.</p> <p>On 4/25/25 at 12:45 PM, R1 was sitting in her room in a wheelchair. R1 stated sometimes she has to wait a while for her call light to be answered. R1 stated I need assistance to get up and when using the toilet. Last night I had to go to the bathroom and a CNA (Certified Nursing Assistant, unknown) came in at supper time and I told her that I needed to use the toilet. The CNA said she would go get someone to help her transfer me, but she never came back. I hit my call light, but I didn't see anyone until 11:30 PM. I had already soiled myself because I couldn't hold it that long. I can't transfer safely because my legs get wobbly, so I need help with going to the bathroom, so I just had to sit in the mess and wait. When the staff came in at 11:30 PM, they helped get me cleaned up. I don't know if it was a staffing problem or what. While waiting for someone to come I just felt very dirty. I was so upset that it happened, and I wish it didn't.</p> <p>On 4/25/25 at 12:55 PM, V8 (Certified Nursing Assistant) confirmed she is working on R1's hall. V8 stated (R1) was very upset this morning when I came in the see her. She said first thing when I entered her room that last night, she had a CNA (unknown) that told her she would come back and help her but never did. She said she ended up wetting herself and that she didn't receive help with getting cleaned up for several hours. (R1) is a nice resident and rarely pushes her call light because she doesn't want to bother. I felt bad for her because I could tell it made her so upset and she had it on her mind throughout the night. I am not sure how many were here at that time yesterday, but she needed assistance to the bathroom and was upset that she couldn't hold it.</p> <p>On 4/26/25 at 2:45 PM, V1 (Administrator in Training) stated he is handling nursing and nursing assistant concerns right now due to the facility not having a Director of Nursing or Interim director in that role, currently. V1 stated he was unaware that R1 waited several hours for toileting assistance or that she had an incontinent accident as a result. V1 confirmed waiting even one hour to receive assistance is not acceptable.</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38396</p> <p>Based on observation, interview and record review, the facility failed to ensure that direct resident care staffing hours are adequate to meet the needs of residents in the facility. This failure has the potential to affect all 75 residents residing in the facility.</p> <p>Findings include:</p> <p>The facility's Facility Assessment, dated 4/15/25, documents the facility has an average daily census of 77. This assessment documents Assuming our normal average level of acuity our staffing levels are set per the table (for daily staffing). Any new admit with higher level medical and care needs will result in a review and assessments of the current staffing ratios to ensure appropriate coverage to ensure resident comfort and ability to meet needs timely. The staffing will be adjusted as needed based on changes to the resident population. Resident PDPM (Patient Driven Payment Model) categories will assist with determining staffing needs based on acuity. Direct care staff, residents, resident representatives, and others' feedback is considered when allocating direct care staff hours. This same assessment documents a table to include expected staffing hours Day-shift (6 AM-2 PM) CNA (Certified Nursing Assistant) hours total 92 hours. Evening shift (2 PM-10 PM) CNA hours total 56 hours. Night shift (10 PM-6 AM) CNA hours total 48 hours (expected 196 Certified Nursing Assistant hours in a 24 hour time frame.)</p> <p>The facility's Resident's Call System policy, dated 9/2022, documents Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized work station. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor. Calls for assistance are answered as soon as possible, but no later than 5 minutes. Urgent requests for assistance are addressed immediately.</p> <p>The facility's Assistance with Meals policy, dated 3/2022, documents Residents shall receive assistance with meals in a manner that meets the individual needs of each resident. Dining Room Residents: All residents will be encouraged to eat in the dining room. Facility staff will serve resident trays and will help residents who require assistance with eating. Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity.</p> <p>The facility's Resident Council minutes, dated 2/4/25, documents eleven residents were present at the meeting. These minutes also document resident concerns Residents stated that beds are not being made, and sheets are not getting changed is still an issue, and call lights being answered in a timely manner. Then residents stated that when they ask for help, they have been told no.</p> <p>The facility's Resident Council minutes, dated 4/1/25, documents eight residents were present at the meeting. These minutes also document resident concerns Residents down 300/400 call lights are not being answered in a timely manner, bed sheets are not being changed.</p> <p>R1's Toileting assessment, dated 4/21/25, documents R1 requires assistance of one staff for toileting.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>R1's current Brief Interview for Mental Status assessment (BIMS), dated 4/7/25, documents R1 has a BIMS of 14 indicating R1 is cognitively intact.</p> <p>On 4/25/25 at 12:45 PM, R1 was sitting in her room in a wheelchair. R1 stated sometimes she has to wait a while for her call light to be answered. R1 stated I need assistance to get up and when using the toilet. Last night I had to go to the bathroom and a CNA (Certified Nursing Assistant, unknown) came in at supper time and I told her that I needed to use the toilet. The CNA said she would go get someone to help her transfer me, but she never came back. I hit my call light, but I didn't see anyone until 11:30 PM. I had already soiled myself because I couldn't hold it that long. I can't transfer safely because my legs get wobbly, so I need help with going to the bathroom, so I just had to sit in the mess and wait. When the staff came in at 11:30 PM, they helped get me cleaned up. I don't know if it was a staffing problem or what.</p> <p>R2's current Care Plan, dated 9/17/24, documents R2 has a diagnosis of Dementia. This care plan also documents I need setup help and feeding assist since my hospitalization on [DATE]. I will require limited/extensive/total assistance with eating due to dementia and weakness. I receive a regular diet with regular consistency per my physician orders. I am able to feed myself but will tell staff I am not able to feed myself and want them to feed me. My appetite varies due to behaviors, and I refuse to eat. I will act as if I am sleeping at the table, and when staff attempts to encourage me or wake me, I will yell out at them. I need encouragement to eat, and reminders to finish my meal.</p> <p>R2's Eating/Toileting assessment, dated 1/26/25, documents R2 requires physical assistance of one person for eating.</p> <p>On 4/25/25 at 12:20 PM, R2 was sitting in the facility's dining room at a table. R2 was leaning forward and had his eyes closed at the table. R2's lunch plate contained uneaten fish, rice, brussel sprouts and a roll. R2 had consumed zero percent of his meal.</p> <p>R3's current care plan, dated 6/3/2020, documents I need set up assistance with verbal cues and supervision with eating. Please set my meal up for me and encourage me to eat. Assist me with eating if I am not feeding myself.</p> <p>On 4/25/25 at 12:22 PM, R3 was in the facility's (feeding assistance) dining room sitting at a table by herself and sleeping. R3's plate contained a full serving of uneaten fish, rice, brussel sprouts, a roll and dessert. Less than 25% of R3's entire meal was eaten. At this time no Certified Nursing Assistants or resident care staff were in the dining area.</p> <p>On 4/25/25 at 12:25 PM, V11 (Dietary Aide/Dishwasher) was in the (feeding assistance) dining room and stated he is just filling the hall cart. V11 stated Usually we have nursing assistant staff in here to help residents with eating. This dining room is meant for a lower noise level and less distractions. We did have a couple aides in here, but I am not sure where they went.</p> <p>On 4/25/25 at 12:35 PM, several residents in the (feeding assistance) dining room remain without any facility staff members present. R2 and R3 continued sitting at tables with full plates of food in front of them. R2 was awake and yelled out occasionally. R3 continued to be sleeping at her table.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 4/25/25 at 12:40 PM, V8 (Certified Nursing Assistant) stated I am the only CNA on the 500 hall today. I have multiple residents who are (mechanical) lift transfers or require assistance of two staff with getting transferred. Residents who need help with eating are in the dining room. It seems like we don't have enough staff to keep up with all that needs done. I would say the past month it has gotten way worse. We don't have enough scheduled sometimes and then other times we have call offs, and they don't get covered. We will get texts on our days off, but it might only be thirty minutes before the shift starts and I can't just come in at that short notice.</p> <p>On 4/25/25 at 11:15 AM, V3 (Licensed Practical Nurse) stated It's a mess here. I have two aides (in my hall) today but typically I will only have one. It's just really bad here and staffing isn't enough. I don't know how we're still going like this.</p> <p>On 4/25/25 at 1:05 PM, V1 (Administrator In Training) stated The (feeding assistance) dining room is considered the assisted dining room and residents who eat in there need less distractions and staff to help with meals.</p> <p>On 4/26/25 at 1:55 PM, V2 (Human Resources/ Scheduler) confirmed she is the one who completes schedules for nurses and CNAs. V2 stated I know recently we've had a lot of call-ins. When staff call in last minute it's not easy to find people to cover those gaps. I don't know that we have been below state minimums, but I don't know what those are. We currently do not have a DON (Director of Nursing) or ICP (Infection Control Preventionist) and we do not have anyone interim in those positions Staff will sometimes complain to me that they don't want to work extra or pick up extra days and it's because they are burnt out. I get that. We are trying to incentive people to pick up overtime hours and work extra but they don't want to, and I don't really have an answer to make it better.</p> <p>The facility's Daily staff posting, dated 4/25/25, documents on 4/25/25 (of the expected 196 CNA hours based on the Facility Assessment) the facility was staffed with 116 CNA hours in the 24 hour time frame.</p> <p>The facility's Resident Census Report, dated 4/25/25 and provided by V1, documents the facility has 75 residents residing in the facility.</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>38396</p> <p>Based on interview and record review the facility failed to provide services of a full time Director of Nursing. This failure has the potential to affect all 75 residents residing in the facility.</p> <p>Findings include:</p> <p>The facility's Facility Assessment, dated 4/15/25, documents the facility has an average census of 77 residents. This assessment also documents the facility will provide nursing services that include one full-time Director of Nursing.</p> <p>The facility's Director of Nursing job description, dated 1/2011, documents The Director of Nursing (DON) will plan, organize, develop and direct the facility's nursing services in accordance with all current federal, state and corporate standards, regulations, and guidelines to assure the highest degree of quality care. The Director of Nursing is responsible for the nursing services provided within the facility twenty-four (24) hours a day, seven days a week, including ensuring proper staffing & supervision at all times. This encompasses the development & implementation of patient care programs, nursing policies & procedures, nursing service objectives, standards of practice & all aspects of plans of care.</p> <p>On 4/25/25 at 11:35 AM, V1 (Administrator in Training) stated We had a large number of management positions step down all on the same day. Our (former) DON (V5) came to me, I believe on 4/9/25 and went back to only working as a floor nurse on 4/13/25. When someone calls off the nurse managers have to cover the floor. That is a lot of why my managers stepped down. V1 confirmed the facility does not have anyone filling the Director of Nursing role for the interim time.</p> <p>The facility's Resident Census Report, dated 4/25/25 and provided by V1, documents the facility has 75 residents residing in the facility.</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>38396</p> <p>Based on observation, interview and record review, the facility failed to ensure the daily staffing postings document the number of licensed nurses and nursing assistants in the facility for a 24 hour period. This failure has the potential to affect all 75 residents residing in the facility.</p> <p>Findings include:</p> <p>The facility's daily staffing posted sheets, dated 3/25/25-4/25/25, do not document the total number of Certified Nursing Assistant (CNA) hours, Registered Nurse (RN) hours or Licensed Practical Nurse (LPN) hours.</p> <p>On 4/25/25 at 11:40 AM, the facility's daily staff posting was hanging next to the employee time punch clock at the entrance of the facility. This staff posting does not document the number of hours for LPN, RN and CNAs in a 24 hour period.</p> <p>On 4/25/25 at 11:55 AM, V1 (Administrator In Training) provided 30 days of daily staffing sheets from 3/25/25-4/25/25 and all sheets did not include the total number of hours for each licensed nurse and nursing assistant. V1 confirmed the staffing sheets provided for the last 30 days are the actual daily staffing sheets that the facility uses for a daily staff posting.</p> <p>On 4/26/25 at 1:55 PM, V2 (Human Resources/ Scheduler) stated The daily staffing sheets that we post are typically two pages and lists the employees working that day. We post those in two common areas next to time clocks. They do not total the hours for nurses and nursing assistants. They are printed from out of our scheduling system, and I don't think it offers that breakdown. We don't list out RN, LPN and CNA hours. It is just by a number of who's on the shift for nursing.</p> <p>On 4/26/25 at 2:45 PM, V1 stated I have been in the building since 10/30/24. I have worked other places, and we used to fill out the daily staff posting that listed the total RN, LPN and CNA hours. Our (facility) sheets that we post are just printed from the program we use for scheduling, but it doesn't provide the hours totaled. It was like this before I came so it's just been continued that way.</p> <p>The facility's Resident Census Report, dated 4/25/25 and provided by V1, documents the facility has 75 residents residing in the facility.</p>

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<p>F 0882</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.</p> <p>38396</p> <p>Based on interview and record review the facility failed to provide services of a Infection Control Preventionist. This failure has the potential to affect all 75 residents residing in the facility.</p> <p>Findings include:</p> <p>The facility's Facility Assessment, dated 4/15/25, documents the facility has an average census of 77 residents. This assessment also documents the facility will provide nursing services that include a Infection Preventionist.</p> <p>The facility's Quality/Infection Control job description, dated 1/1/25, documents As directed and counseled by the DON (Director of nursing), will supervise and direct the care provided to the residents, with a focus on attaining clinical outcomes established by the physician and in the care plan. Communicates with physicians and families any time there is a significant change in the resident's condition. Further duties include: monitoring patient care by reviewing start of care and resumption of care documentation, assessing patient clinical outcomes, analyzing the processes and procedures used in patient care, and ensuring all patients receive care based on these standards. This description also documents Maintains a consistent presence on the floor and makes rounds several times during the work day to ensure residents' care is being provided according to standard-of-care and polices. Ensure residents' needs for daily living are met, and advise and instruct floor staff of residents' needs. Ensure the clinical outcomes that physicians want to see are carried out to the best of our abilities. Ensure tasks are completed timely, always informing floor nurse of any problems to help with completion of these tasks. Meet with all shifts to ensure residents' needs are observed, and any issues are addressed on each shift along with the DON. Responsible for monitoring that isolation and infection control protocols are being followed. Assist in and observe the dining rooms as feasible. Ensure residents are given choices and any problems with intake or dietary issues are addressed to Dietary Supervisor and DON.</p> <p>On 4/25/25 at 11:35 AM, V1 (Administrator in Training) stated We had a large number of management positions step down all on the same day. Our (former) Assistant Director of Nursing/ Infection Control Preventionist (V6) stopped working here about two weeks ago. V1 confirmed the facility does not have anyone filling the Infection Preventionist role for the interim time.</p> <p>The facility's Resident Census Report, dated 4/25/25 and provided by V1, documents the facility has 75 residents residing in the facility.</p>		