

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145949	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2025
NAME OF PROVIDER OR SUPPLIER Hillcrest Home		STREET ADDRESS, CITY, STATE, ZIP CODE 14688 Illinois Highway 82 Geneseo, IL 61254	

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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure Advance Directives reflect resident preference for one (R4) of one resident reviewed for Advance Directives in the sample of 30.</p> <p>Findings include:</p> <p>The facility's POLST (Practitioner Order for Life-Sustaining Treatment) policy and procedure, dated 3/20/23, documents the POLST is an important component of advance care planning that emphasizes eliciting, documenting, and honoring patients' preferences about treatments they want to choose or decline during a medical emergency or as their health status changes. The POLST is to be completed or reviewed with the resident and/or Healthcare Power of Attorney, and/or surrogate or guardian. A POLST is not a one-and-done document and is to be reviewed periodically. The POLST order set is intended to be dynamic, reflecting a resident's current condition and preferences about medical treatments.</p> <p>The POLST form for R4, dated 1/10/22, documents If patient has no pulse and is not breathing and Do Not Attempt Resuscitation/DNR</p> <p>The current Order Summary Report and current Care Plan document R4 as a DNR.</p> <p>The clinical medical record for R4 does not document any discussions were had with R4 regarding R4's wishes for Code Status.</p> <p>The admission MDS (Minimum Data Set) Assessments for R4, dated 1/16/22 (admission date) and Quarterly MDS assessment dated [DATE], document R4 as cognitively intact.</p> <p>On 5/21/25 at 2:40 PM, R4 stated no one has asked him what his wishes were if his heart stopped beating and he stopped breathing. R4 stated, without hesitation, I want them to do everything if I die.</p> <p>On 5/23/25 at 9:43 AM V11 SSD (Social Service Director) stated she talks with residents and family regarding Code status during the resident admission or readmission, quarterly, and if there is a significant change in condition. If the family or representative, or legal guardian are not here V11 SSD calls them on the telephone to discuss Code Status. If a resident is alert and oriented the patient makes the decision. We use the BIMS for cognition. V11 SSD stated she calls V17 (R4's) State Guardian, discusses R4's Code Status with her, V17 makes decisions for R4, and R4 is aware of the decisions made.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145949	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2025
NAME OF PROVIDER OR SUPPLIER Hillcrest Home		STREET ADDRESS, CITY, STATE, ZIP CODE 14688 Illinois Highway 82 Geneseo, IL 61254	

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 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>Based on interview and record review, the facility failed to notify the Ombudsman of all hospital discharge/transfers for four of four (R30, R31, R44, and R48) residents reviewed for hospitalization in a sample of 30.</p> <p>Findings include:</p> <p>The facility's Hospital Tracking Portal, dated 2/1/25 to 5/23/25, documents R30, R31, R44, and R48 were transferred out to the hospital.</p> <p>The facility's Admit Discharge report, dated February 2025, does not include R30, R31, R44, or R48.</p> <p>On 5/22/25, at 3:35pm, V12 Business Office Manager/BOM stated that the Admit Discharge report that V12 sends to the Ombudsman does not include the Private Pay residents. V12 was unaware that it should include the Private Pay residents as well.</p> <p>The facility's Daily Census, dated 5/20/25, documents R30, R31, R44, and R48 have a Primary Payer source of Private Pay.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145949	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2025
NAME OF PROVIDER OR SUPPLIER Hillcrest Home		STREET ADDRESS, CITY, STATE, ZIP CODE 14688 Illinois Highway 82 Geneseo, IL 61254	
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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>Based on observation, interview and record review, the facility failed to ensure the resident's environment was kept free from cross contamination during wound care for one of ten residents (R31) who receive wound care. These failures have the potential to affect all resident who reside in the facility with a current census of 46 residents.</p> <p>Findings include:</p> <p>The facility's undated Procedure for Clean Dressing Technique policy documents the following Take treatment cart to the resident's room, but not in contact with the resident belongings. Gather and set up supplies in the resident area. Establish clean field (can be unsterile plastic field, clean linen, etc.) not on the treatment cart.</p> <p>The facility's current Weekly Wound Tracking Forms identify ten residents (R1, R4, R5, R7, R8, R9, R13, R16, R31, R34) who currently are receiving wound care treatments in the facility.</p> <p>R31's Physicians Orders include the following pressure ulcer/wound care orders Cleanse Sacrum with NS (Normal Saline) apply Santyl (wound treatment ointment) to wound bed and cover with (dry dressing) and secure with tape daily and PRN (as needed) every day shift for wound care and as needed for wound care.</p> <p>On 5/22/25 at approximately 11:00 AM, V3 (Wound Nurse and Resident Care Coordinator) wheeled the facility's treatment cart into R31's room, removed R1's wound care supplies from a drawer in the cart and placed them on a clean under pad on the top of cart, including gauze pads, saline cleansing liquid, cloth tape, dry dressing and medicated ointment. V3 performed wound care for R31. After performing R31's wound care, V3 rolled the treatment cart out of R31's room and into the hallway. The wound care supplies for all residents receiving wound care are present in the facility's treatment cart.</p> <p>On 5/22/25 at 11:18 AM, V3 stated she does bring the treatment cart into residents' rooms for wound care treatments and stated, I usually put the treatment cart at the other end of (the resident's) room.</p> <p>On 5/23/25 at 10:30 AM, V4 (Infection Control Coordinator) stated the facility's treatment cart should remain outside the resident's room and should not be brought onto a resident's room.</p> <p>On 5/23/25 at approximately 11:30 AM, V4 provided the facility's Procedure for Clean Dressing Technique policy and verified the treatment cart may be taken to the resident's room door but not inside the resident's room.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145949	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2025
NAME OF PROVIDER OR SUPPLIER Hillcrest Home		STREET ADDRESS, CITY, STATE, ZIP CODE 14688 Illinois Highway 82 Geneseo, IL 61254	
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>2. The facility's Fall log dated May 2025 documents R9 had a fall on 5/4/25 at 1:15 PM.</p> <p>The Fall Risk Assessment for R9, dated 3/5/25 documents R9 is at Moderate Risk for falls.</p> <p>The facility's Fall Investigation for R9, dated 5/4/25, documents R9 stated My foot wasn't in the right position, then I started just going down. V15's (Agency CNA/Certified Nursing Assistant) witness statement documents V15 was Transferring (R9) into wheelchair from toilet via (mechanical lift), footrest on wheelchair came down, footrest hit (R9's) foot causing (R9) to slip and be lowered to floor.</p> <p>The current Transfer Care Plan for R9 documents R9 requires extensive assistance for transfers. Interventions include to place R9's feet on foot plate of mechanical stand lift and fasten safety strap around R9's legs with knees against the pad. This same Care Plan was revised to include a new fall on 5/4/25. R9 was being transferred by V15 (Agency CNA) and R9's right leg wasn't positioned properly. R9 had to be lowered to the floor for R9's safety.</p> <p>On 5/21/25 at 2:30 PM, R9 stated V15 (Agency CNA) transferred her and didn't put her feet on the lift platform correctly, did not put the strap behind her legs, and did not listen to R9. R9 stated My right foot was curled and not flat. V15 (Agency CNA) said Let go, I got you. When V15 (Agency CNA) started raising the lift (R9's) foot slipped and I had a soft fall.</p> <p>On 5/22/25 at 11:53 AM, V2 (DON/Director of Nursing) stated she does all the fall investigations for the facility and determines the root cause analysis for each resident fall. V2 stated V15 transferred R9 without fastening the lift strap behind R9's legs and should have; and confirmed improper foot positioning prior to transfer. V2 stated the intervention would be for V15 (Agency CNA) to be re-educated on proper transfers.</p> <p>Based on interview and record review, the facility failed to ensure residents were safely transferred, monitored post fall and that the accident was appropriately investigated for two of eight residents (R9, R13) reviewed for accidents in a sample of 30 residents.</p> <p>Findings include:</p> <p>The Fall Prevention Policy dated 8/31/21 documents: All residents will receive adequate supervision, assistance and assistive devices to aid in the prevention of falls. All falls are to be investigated and monitored. The Director of Nursing and/or designee is responsible for coordinating all investigations. An accident is an unexpected, unintended event that can cause a resident bodily injury. A 'fall' is the unintentional coming to rest on a lower surface, such as a chair, the bed or the floor or onto the next lower surface. Investigative guidelines documents to call a Post-Fall Huddle and complete a Fall Report, obtain detailed statement from any witnesses and document in the Nurses Notes. Document vital signs, neurological checks, medication taken, last time resident was seen and any other pertinent observations. Continue to observe resident throughout shift and provide documentation. Each nurse, each shift will observe resident and document for 72 hours in the resident's medical record. Monitor closely for any physical or neurological changes. Discuss the incident in morning meeting for review as Interdisciplinary team and update care plan.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145949	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2025
NAME OF PROVIDER OR SUPPLIER Hillcrest Home		STREET ADDRESS, CITY, STATE, ZIP CODE 14688 Illinois Highway 82 Geneseo, IL 61254	
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. R13's current Care Plan documents R13 was at risk for falls characterized by history of falls/injury, multiple risk factors related to: impaired balance, unsteady gait, hypocalcemia and weakness. On 3/21/25 R13 was noted to be on the floor by her wheelchair after she attempted to hang up her phone; did not have her wheelchair brakes locked when she was leaning forward to hang up her phone; was re-educated to lock her wheelchair brakes or use the call light to ask for help when needed; obtained a skin tear to her right elbow; monitor for signs and symptoms of infection; refer to therapy; and on 3/24/2025 to obtain an x-ray of right elbow; and to refer R13 to the wound doctor.</p> <p>R13's Physician's Order dated 3/21/25 documents to place and keep right elbow steri-strips in place, monitor for signs and symptoms of infection every shift for skin tear for two weeks.</p> <p>V5's (Advanced Registered Nurse Practitioner) Progress Note dated 3/24/25 documents R13 complained of right elbow pain and worsened with movement. The right elbow did have a deep laceration and complained of being sore from the fall, but the only specific area is the right elbow. There were no steri-strips on the elbow at the time of V5's assessment. V5 ordered an x-ray of the right elbow, prophylactically prescribed antibiotics for ten days and made a referral to the wound doctor.</p> <p>R13's Progress Note dated 3/24/25 documents a right elbow x-ray was conducted. On 3/25/25, the right elbow x-ray was reported as a fracture was not excluded but was inconclusive. On 3/27/25, the Progress Note documents R13's right elbow x-ray was negative.</p> <p>V6's (Wound Care Physician) Progress Note dated 3/26/25 documents Non-Pressure Wound of the right elbow full thickness caused by trauma/injury greater than four days ago and measured three cm (centimeters) by 1.6 cm by 0.8 cm; surface area 4.80 cm; undermining 1.2 cm, to apply collagen sheet to wound once daily and as needed for 30 days; apply gauze island with border once daily and as needed for 30 days. V6's treatments as listed on the Wound Log document on 4/2/25, 4/9/25 and 4/16/25, R13's right elbow wound had worsened and surgical debridement was conducted; 4/30/25 wound was debrided and unchanged; and on 5/7/25 wound was debrided and improved. V6 conducted weekly visits until 5/21/25 when wound was declared healed.</p> <p>The Fall Investigation dated 3/21/25 did not include an interview from V20 (Occupational Therapist) or V21 (Physical Therapy Assistant) who observed R13's fall, documented injuries as a bruise on the right forearm, redness to upper-mid back vertebrae and a skin tear to right elbow and no injuries observed post incident.</p> <p>R13's medical record did not include vital sign monitoring and/or an assessment of her right elbow wound for 72 hours each shift per policy (3/21/25, 3/22/25, 3/24/25) or for two weeks each shift per physician's order.</p> <p>The Interdisciplinary Note (IDT) dated 3/30/25 (nine days post fall incident) documents R13's fall details and post fall findings were discussed/reviewed, although does not include an interview from V20 (Occupational Therapist) or V21 (Physical Therapy Assistant) who observed and responded to R13's fall, why R13's deep laceration that required treatment by a wound doctor and complaints of pain of her right elbow was not accurately assessed until 3/24/25 when V5 (Advanced Registered Nurse Practitioner) conducted rounds.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145949	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2025
NAME OF PROVIDER OR SUPPLIER Hillcrest Home		STREET ADDRESS, CITY, STATE, ZIP CODE 14688 Illinois Highway 82 Geneseo, IL 61254	

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/23/25 at 9:50 AM, V20 (Occupational Therapist) and V21 (Physical Therapy Assistant) stated they were in the room across from R13 and witnessed R13 reach forward to hang the phone up and slid off the front of the wheelchair onto her butt then rolled backward onto her back. V20 and V21 ran into R13's room and the nurse came in soon after. I didn't even know she cut her arm until the next day.</p> <p>On 5/23/25 at 11:00 AM, V2 (Director of Nursing) stated R13's right arm laceration was not appropriately assessed due to positioning of the arm during assessment; agreed post fall assessments were not appropriately conducted and/or documented per policy; and agreed the IDT met nine days after R13's fall.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145949	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2025
NAME OF PROVIDER OR SUPPLIER Hillcrest Home		STREET ADDRESS, CITY, STATE, ZIP CODE 14688 Illinois Highway 82 Geneseo, IL 61254	
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 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>Based on observation, interview, and record review, the facility failed to ensure their posted nurse staffing information was in a clear format and included the name of the facility. This has the potential to affect all 46 residents in the facility.</p> <p>On 5/20/25, at 12:30pm, the facility's Minimum Daily Staffing Calculations sheet dated 5/20/25 is hanging in the front hallway.</p> <p>The facility's Minimum Daily Staffing Calculations tool sheet, dated 5/20/25, does not include the name of the facility and is not in a clear, readable format. This posting documents the numbers to calculate the total of licensed nurses and non-nurse staffing additional direct care hours needed which is then multiplied by the designated number of FTEs (full time equivalents) to result in the total number of hours needed. The number of actual Registered Nurses/RNs, Licensed Practical Nurses/LPNs, and Certified Nursing Assistants/CNAs is written in off to the side.</p> <p>On 5/23/25, at 11:20am, V2 Director of Nursing/DON confirmed the Minimum Daily Staffing Calculations sheet is used to calculate the number of staff needed and is the staffing sheet they use to post in the hallway and have used it for a long time.</p> <p>The facility's Long-Term Care Facility Application for Medicare and Medicaid dated 5/20/25, documents 46 residents currently reside in the facility.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145949	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2025
NAME OF PROVIDER OR SUPPLIER Hillcrest Home		STREET ADDRESS, CITY, STATE, ZIP CODE 14688 Illinois Highway 82 Geneseo, IL 61254	
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview and record review, the facility failed to ensure infection control practices were utilized while serving meals in the dining room. These failures have the potential to affect all resident who reside in the facility with a current census of 46 residents.</p> <p>Findings include:</p> <p>The Facility Resident Census Roster and Facility Matrix/802 dated 5/20/25 were reviewed. The Census Roster documented 46 Residents resided in the Facility.</p> <p>The Illinois Food Handler Training power point utilized for training facility dietary staff dated 6/3/16 documents food can become unsafe if staff practice poor personal hygiene. Personal hygiene consists of good hand washing practices, proper glove use, proper hand care and personal cleanliness. Wash hands between tasks.</p> <p>V18's (Dietary Aide) Certificate of Completion of the Illinois Food Handler Non-Restaurant Training was dated as completed on 12/1/23.</p> <p>On 5/20/25 at 11:14 AM, V18 was observed to be at the drink station in the dining room, put two meal tickets in her mouth, one meal ticket fell from her mouth onto the floor, she picked it up off the floor with her bare hand, poured apple juice into a glass and handed the glass off to another staff member, then made three cups of hot chocolate, picked up the three cups of hot chocolate and delivered them to R31. V18 then went to the serving window to deliver meal trays without conducting proper hand hygiene.</p> <p>On 5/23/25 at 11:55 AM, V22 (Dietary Supervisor) stated V18 should not have held the meal tickets in her mouth or picked up the meal ticket off the floor without conduction hand hygiene prior to making and serving R31 his drinks. V22 stated V18 had a current Certification of Completion of the State's Food Handler Training and knows better than to cross contaminate residents' food and/or drinks.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145949	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2025
NAME OF PROVIDER OR SUPPLIER Hillcrest Home		STREET ADDRESS, CITY, STATE, ZIP CODE 14688 Illinois Highway 82 Geneseo, IL 61254	
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 0837</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility.</p> <p>Based on observation, interview and record review, the facility's Governing Body failed to employ a licensed Administrator to oversee and manage the everyday operations of the facility. This failure has the potential to affect all 46 residents residing within the facility.</p> <p>Findings include:</p> <p>The Facility Resident Census Roster and Facility Matrix/802 dated 5/20/25 were reviewed. The Census Roster documented 46 Residents resided in the Facility.</p> <p>The Administrator's Job Description (not dated) documents the Administrator supervises all departments and employees and is responsible for planning, organizing, staffing, directing and coordinating the facility to ensure quality of care for residents, be knowledgeable of and implement federal, state, local laws and regulations applicable to the facility, residents, personnel and physical plant. The Administrator must hold a current, unencumbered nursing facility Administrator's license.</p> <p>On 5/20/25 from 9:15 AM through 3:30 PM, on 5/21/25 from 9:00 AM through 3:30 PM, on 5/22/25 from 9:00 AM through 3:30 PM and on 5/23/25 from 9:00 AM through 3:30 PM there was no licensed administrator within the building and no posted Administrator's license.</p> <p>On 05/20/25 at 9:30 AM, V2 (Director of Nursing) stated the facility has not had an Administrator since 4/9/25 and she was the acting Administrator.V2 stated V1 (County Administrator) was the facility's resource. V2 agreed the Facility did not have an Administrator license posted within the facility.</p>		