STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145400	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster Village	2025 East Lincoln Street Bloomington, IL 61701

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure physician-ordered daily weights were obtained and documented for two (R1 and R4) of the four residents reviewed for edema in a total sample of 10 residents.Findings include:1. R4's Progress note, dated 2/28/2026, documents that R4 discharged from the facility on 2/28/26. R4's Minimum Data Set (MDS), dated [DATE], documents R4 had an active diagnosis of heart failure.R4's Physician Order Summary Report, dated 2/20/2026, documents an order for a daily weight related to history of congestive heart failure (CHF).R4's Medication Administration Record, dated February 2026, documents that no weights were obtained or documented on 2/20/2026, 2/22/2026, 2/23/2026, and 2/24/2026.R4's nursing note, dated 2/28/2026, documented that R4 was observed with an increase in shortness of breath and increased swelling. It also documented that R4 was transferred to the hospital on this date.R4's undated Weight Summary documents that R4's weight on 2/19/2026 was 191.0 pounds. On 2/21/2026 R4's weight was 200.8 pounds. R4's electronic medical record does not document notification to physicians of weight variance.On 4/20/2026 at 10:09 AM, V4 (R4's) family member, stated that R4 has a history of congestive heart failure (CHF) and V4 was concerned about R4 retaining fluid. V4 stated that R4 has been noted to have swelling and increased shortness of breath. V4 stated that R4 was supposed to be weighed daily but the facility has not weighed R4 daily.On 4/21/2026 at 12:52PM, V15 Registered Nurse (RN) stated that V15 was the nurse for R4 on 2/28/2026 and observed R4 with increased swelling to both legs and arms that morning. V15 stated that R4 was also observed with altered mental status that morning. V15 stated that V4 (R4's) family member was in the facility visiting R4 at that time and requested for R4 to be sent out to hospital for evaluation. V15 RN stated that V15 notified V14 Nurse Practitioner (NP) and gave order to send R4 to hospital. V15 stated that R4 had a history of CHF and should have been weighed daily.On 4/21/2026 at 12: 38 PM, V14 Nurse Practitioner (NP), stated that R4 had history of CHF and should have weighed daily. V14 stated that V14 would expect nurses to notify her for at least three pounds weight gain in 24 hours or at least five pounds weight gain in a week to address the issue with interventions.On 4/21/2026 at 11:31 AM, V2 Director of Nursing (DON) stated that based on R4's electronic records, R4's weights were not obtained daily and stated R4 should have weighed daily per physician's order. V2 stated staff should have documented the reason why R4's weights were not obtained. V2 confirmed R4's weights were not documented on multiple dates, and no reasons were documented. V2 stated nurses should notify the physician for weight gain of at least three pounds in 24 hours or at least five pounds in a week.2. R1's Minimum Data Set (MDS) dated [DATE] documents, that R1 has an active diagnosis of heart failure. It also documents that R1 is cognitively intact.R1's Care Plan date initiated 6/11/2018 documents a focus of on-going treatment for congestive heart failure with interventions/tasks dated 6/11/2018 to monitor weight as ordered.R1's Physician's Order, dated 1/13/2026, documents daily weight.R1's Treatment Administration Record, dated 4/21/2026, documents no weights were obtained nor documented on multiple dates of 3/10/2026, 3/11/2026, 3/17/2026, 3/18/2026, 3/22/2026, 3/23/2026, 4/5/2026, 4/7/2026, 4/8/2026, 4/13/2026 and 4/19/2026.On 4/20/2026 at 12:50 PM, R1 was sitting in the recliner in R1's room wearing oxygen at two liters via nasal cannula. R1had ace (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wraps wrapped around both legs. R1 stated R1's legs are swelling because R1 has congestive heart failure (CHF). R1 stated the staff weighs R1 once a week.On 4/20/2026 at 1:19 PM, V10 Registered Nurse (RN), stated that R1 has swelling to both legs due to R1's diagnoses of CHF. V10 stated that staff apply ace wrap to R1's legs before R1 gets up in the morning. V10 stated there are interventions in placed for R1 to manage the swelling including daily weights but R1 refuses at times. V10 stated if R1 refuses to be weighed, nurses should document the refusal.On 4/21/2026 at 11:31 AM, V2 Director of Nursing (DON) stated that based on R1's electronic records, R1's weights were not obtained or documented daily. V2 stated R1 should have weighed daily per physician's order and that staff should have documented the reason why the weights were not obtained. On 4/20/20/2026 at 11:32AM, V7 Registered Nurse, stated that daily weights are to be done for residents with CHF and nurses are to document the reason if weight is not able to be obtained. V7 stated that nurses are to notify the doctor for weight gain of at least three pounds in a day and at least five pounds in a week.On 4/21/2026 at 12: 38 PM, V14 Nurse Practitioner (NP), stated V14 expected the nurses to notify V14 when there are changes in condition including swelling or increase in swelling.On 4/21/2026 at 11:31 AM, V2 Director of Nursing (DON), stated that the staff should follow doctors order for daily weight and staff should document the reason if weight is not obtained in resident's chart.Facility's Acute Change in Condition and Clinical Monitoring Policy, dated 2/23/2026, documents, Daily weights will be obtained per physician order and documented in TAR/MAR (treatment administration record/medication administration record). If the weight cannot be obtained due to refusal, absence, or clinical limitation: The reason must be documented in the TAR and progress note. A nursing assessment of fluid status must be completed and documented.