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	05/29/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to protect resident's rights to be free from resident to resident physical abuse. This failure affects two of three residents (R8, R9) reviewed for abuse on the sample list of 25. Findings Include: The facility's Abuse Prevention, Reporting, and Investigation Policy revised May 2026 documents the facility prohibits and is committed to preventing abuse involving any resident. Abuse is the willful infliction of injury. Physical abuse includes hitting, slapping, rough handling or unnecessary force. It is any intentional physical action that causes or could cause harm. R8's Care Plan dated 5/7/26 documents R8 is diagnosed with Alzheimer's Disease. R8 forgets safety concerns and will walk in his room and hallway without assistance. R8 has a history of wandering. R8's Minimum Data Set, dated [DATE] documents R8 is severely cognitively impaired. R8 has physical behavioral symptoms directed towards others such as hitting, kicking, pushing, and grabbing. These behaviors can significantly interfere with R8's participation in activities or social interactions. R8's behaviors can put others at significant risk for physical injury, significantly intrude on the privacy of others, and significantly disrupt care or the living environment. R8's wandering behavior occurred daily. R8's wandering significantly intrudes on the privacy of others. R8's Behavior Note dated 5/29/26 documents V5 Licensed Practical Nurse (LPN) heard her name being yelled and entered R9's room. R8 was standing over R9's bedside and holding R9's wrists bilaterally. R9 was yelling for V5's help. V5 entered the room and removed R8 from R9's bedside and redirected him to his room. R9's Care Plan dated 5/5/26 documents R9 is diagnosed with Difficulty Walking and has Impaired coping and Impaired Physical Mobility. R9's Minimum Dated Set dated 5/6/26 documents R9 is cognitively intact. On 5/26/26 at 3:15 PM R9 stated on 5/20/26 at approximately 7:45 PM R8 walked into R9's room uninvited. R9 stated R8 walked over to R9's bed. R9 told R8 to turn around and go out of his room. R8 began to hit R9 and R9 placed his arms up in order to block the blows coming from R8. R8 then grabbed a hold of R9's wrists and R9 stated he began to yell out V5 LPN's name for help. R9 stated V5 entered his room and was able to get R8 to let go and go back into his own room. R9 stated he told staff he did not feel safe any longer, however, did not feel like he should have to move rooms since he was the victim. R9 stated he was told by staff that R8 would have one-on-one monitored from that time forward and R9 stated he felt a little better after hearing that. R9 stated he thought about calling the police but did not. R9 stated R8 had often entered his room uninvited prior to this incident however this was the first time R8 got physically aggressive with R9. R9 stated staff did not do a good job supervising R8. On 5/27/26 at 12:51 PM V5 Licensed Practical Nurse (LPN) confirmed she was the nurse on duty on 5/20/26 when R8 went into R9's room uninvited and stood over R9s bed and grabbed both of R9's wrists. V5 stated R9 called her for help, and she was able to get R8 to let go and return to his own room. V5 confirmed the incident was a physical altercation and stated she called V1 Administrator to report it. On 5/27/26 at 3:35 PM V2 Director of Nurses confirmed a physical altercation occurred between R8 and R9 and she charted the incident as a Behavior Note in R8's medical record. V2 confirmed R8 has a history of wandering into the rooms of other residents, however this was the first time R8 got physical with another resident.

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Failures at this level required more than one deficient practice statement. A. Based on observation and interview, the facility failed to maintain the hot water supply in resident bathrooms and showers in safe operating temperatures. This failure affects seven residents (R3, R11, R13, R36, R47, R48, and R52) out of eleven reviewed for water temperatures on the sample list of 25. B. Based on observation, interview, and record review the facility failed to provide adequate supervision for one of three residents (R8) reviewed for wandering on the sample list of 25. Findings include: a. On 05/26/26 at 12:45 PM, while checking a random sample of the water temperatures in resident bathroom hand sinks utilizing an Illinois Department of Public Health digital automatically calibrating thermometer, the hand sink water temperature in room [ROOM NUMBER] was 120.9 degrees Fahrenheit (F). The water temperature in the hand sink in room [ROOM NUMBER] was 123.0 F. The hand sink water temperature in room [ROOM NUMBER] was 116.9 F. The water temperature in the hand sink in room [ROOM NUMBER] was 123.6 F. The temperature of the water in the hand sink in room [ROOM NUMBER] was 119.3 F. The hand sink water temperature in room [ROOM NUMBER] was 117.8 F. On 5/26/26 at 2:12 PM, V3, Maintenance Director, stated the facility checks the water temperatures in the resident bathrooms weekly. V3 stated she has an upper limit of 112 degrees F. On 5/26/26 at 2:18 PM, with V3, Maintenance Director, utilizing a facility digital thermometer, the water temperatures in the resident hand sink and shower in rooms 5146 was 123.0 F and the shower at the same temperature. V3 measured the water temperature in room [ROOM NUMBER], finding the hand sink water at 117.9 F and the shower at 120.2 F. V3 stated the temperatures in the hand sinks and showers was way too high. V3 stated based on the sample temperatures, she would check all the resident rooms in the facility. The facility's Resident Roster dated 5/26/26 documents R3, R11, R13, R36, R47, R48, and R52 reside in the aforementioned rooms. B. R8's Care Plan dated 5/7/26 documents R8 is diagnosed with Alzheimer's Disease. R8 forgets safety concerns and will walk in his room and hallway without assistance. R8 has a history of wandering. R8's Minimum Data Set, dated [DATE] documents R8 is severely cognitively impaired. R8 has physical behavioral symptoms directed towards others such as hitting, kicking, pushing, and grabbing. These behaviors can significantly interfere with R8's participation in activities or social interactions. R8's behaviors can put others at significant risk for physical injury, significantly intrude on the privacy of others, and significantly disrupt care or the living environment. R8's wandering behavior occurred daily. R8's wandering significantly intrudes on the privacy of others. R8's Behavior Note dated 5/29/26 documents V5 Licensed Practical Nurse (LPN) heard her name being yelled and entered R9' room. R8 was standing over R9's bedside and holding R9's wrists bilaterally. R9 was yelling for V5's help. V5 entered the room and removed R8 from R9's bedside and (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	redirected him to his room. R9's Minimum Dated Set dated 5/6/26 documents R9 is cognitively intact. On 5/26/26 at 3:15 PM R9 stated on 5/20/26 at approximately 7:45 PM R8 walked into R9's room uninvited. R9 stated R8 walked over to R9's bed. R9 told R8 to turn around and go out of his room. R8 began to hit R9 and R9 placed his arms up in order to block the blows coming from R8. R8 then grabbed a hold of R9's wrists and R9 stated he began to yell out V5 LPN's name for help. R9 stated V5 entered his room and was able to get R8 to let go and go back into his own room. R9 stated he told staff he did not feel safe any longer, however, did not feel like he should have to move rooms since he was the victim. R9 stated he was told by staff that R8 would have one-on-one monitored from that time forward and R9 stated he felt a little better after hearing that. R9 stated he thought about calling the police but did not. R9 stated R8 had often entered his room uninvited prior to this incident however this was the first time R8 got physically aggressive with R9. R9 stated staff did not do a good job supervising R8. On 5/27/26 at 10:22 AM V4 RN stated R8 is very confused and wanders often into other resident's room. On 5/27/26 at 12:51 PM V5 Licensed Practical Nurse (LPN) confirmed R8 has a history of wandering into the rooms of other residents. On 5/27/26 at 4:49 PM V7 LPN stated R8 wanders a lot and one shift last week R8 had wandered into a female resident's room (unknown) and the resident had to call for staff to help. On 5/28/26 at 9:31 AM V8 LPN stated R8 wanders all of the time. He is very hard to keep out of other resident's rooms because he moves quickly. On 5/28/26 at 10:50 AM R47 stated R8 has wandered into her room on two separate occasions. R47 stated she told R8 to leave and he would take his time leaving but she got up and showed him to the door and shut the door behind him. R47 stated she does want to have to deal with that anymore. On 5/28/26 at 11:05 AM R33 stated R8 wandered into her room uninvited and she told him to get out. R8 was standing by her bathroom door. R33 stated R8 finally turned around and left. On 5/28/26 at 11:10 AM R28 stated R8 came into her room and stood in the doorway however staff came up behind him pretty quickly and redirected him away from her door. On 5/28/26 at 11:15 AM R13 stated she was sleeping and when she woke up, R8 was standing at the end of her bed. R13 stated she did not know him or who he was at the time, and it scared her half to death. R13 stated she wished the facility would do something about it and supervise R8 better because it creates an uneasy environment and she feels like she can't rest peacefully. R13 stated R8 attempted to come into her room again yesterday however staff were already in her room so they told R8 to leave. On 5/27/26 at 3:35 PM V2 Director of Nurses confirmed R8 has a history of wandering into the rooms of other residents. Staff completed every 15-minute checks however they were not doing much so since the incident on 5/20/26, staff are to provide constant supervision. V2 stated sometimes there are call offs or the staff don't have enough to provide constant supervision.