STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155177	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster Village - West Lafayette	2741 N Salisbury St West Lafayette, IN 47906

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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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the physician was notified immediately and on-call services were utilized when a resident had a change of condition for 1 of 3 discharged residents reviewed for notification of change. (Resident 67) Resident 67 was admitted to the hospital with a bowel obstruction, perforated bowel, and necrosis. The resident required surgical intervention and subsequently died.The immediate jeopardy began, on [DATE] around 9:40 p.m., when Resident 67 had a change of condition which included, a complaint of constipation with ongoing diarrhea, increased pain, shortness of breath, loss of bowel sounds, and excessive belching. RN 2 faxed the physician's office at this time. On [DATE] at 1:58 a.m., Resident 67 was yelling out about abdominal pain and excessive belching. RN 3's assessment noted hypoactive bowel sounds. There was no documentation RN 3 contacted a physician. At 3:14 p.m., RN 4's assessment noted shortness of breath, verbal difficulty finishing sentences, nausea with clear phlegm. Resident 67 was sent to the hospital and admitted for surgery. The Administrator and Director of Nursing (DON) were notified of the immediate jeopardy on [DATE] at 4:50 p.m. The immediate jeopardy was removed on [DATE] but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include:The clinical record for Resident 67 was reviewed on [DATE] at 11:55. The diagnoses included, but were not limited to, morbid obesity, constipation, a cardiac pacemaker, right fibular fracture, hypertension with heart failure, atrial fibrillation, repeated falls, and chronic anticoagulation.The hospital notes, dated [DATE] through [DATE], indicated Resident 67 presented to the emergency room from an Independent Living facility, with complaints of multiple falls. He complained about an onset of diarrhea this morning. A scan of the abdomen and pelvis was completed on [DATE], which showed no acute traumatic abnormality and prominent colonic stool burden (a significant buildup of hardened stool in the colon). His abdomen had no distention, was soft, and not tender. Resident 67 was negative for Clostridioides difficile (C-diff) (a bacterium which causes severe, watery diarrhea, fever, nausea, and abdominal pain).A facility admission nursing progress note, dated [DATE] at 6:58 p.m., indicated Resident 67 had arrived at the facility at 5:15 p.m., and had an admission assessment completed. No signs and symptoms of shortness of breath were noted. His abdomen was round, soft and distended. He had bowel sounds in all four quadrants, and his last bowel movement was yesterday. His blood pressure was 152/62, heart rate was 68, respirations were 18 and oxygen saturation was 95%. An admission shortness of breath assessment, dated [DATE], indicated no shortness of breath was exhibited.A nursing progress note, dated [DATE] at 2:38 a.m., indicated the resident did not have shortness of breath, his abdomen was round, soft and distended. He had bowel sounds in all four quadrants. His blood pressure was 149/66, heart rate was 67, respirations were 17 and oxygen saturation was 95%. The bowel movement documentation, dated [DATE] for 7:00 a.m. to 3:00 p.m. shift, indicated the resident had diarrhea. The size was not documented. A nursing progress note, dated [DATE] at 5:20 p.m., indicated the resident did not have shortness of breath, his abdomen was soft, non-tender and distended. He had bowel sounds in all four quadrants. His blood pressure (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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	was 165/77, heart rate was 75, respirations were 17 and oxygen saturation was 93%. A nursing progress note, dated [DATE] at 5:47 p.m., indicated the resident did not have shortness of breath, his abdomen was round, soft, and distended. He had bowel sounds in all four quadrants. His blood pressure was 148/62, heart rate was 62, respirations were 18 and oxygen saturation was 93%. The bowel movement documentation, dated [DATE] for 11:00 p.m. to 7:00 a.m. shift, indicated the resident an x-large bowel movement. The type of bowel movement was not documented.A nursing progress note, dated [DATE] at 1:01 a.m., indicated the resident's abdomen was distended and taut. The resident indicated his abdomen was at baseline. He had bowel sounds in all four quadrants. His blood pressure was 155/61, heart rate was 73, respirations were 20 and oxygen saturation was 95%. The bowel movement documentation, dated [DATE] for 7:00 a.m. to 3:00 p.m. shift, indicated the resident had diarrhea. The size was not documented. A nursing progress note, dated [DATE] at 3:06 p.m., indicated the resident did not have shortness of breath, his abdomen was soft, non-tender and distended. He had bowel sounds in all four quadrants. His blood pressure was 165/77, heart rate was 75, respirations were 17 and oxygen saturation was 93%. A nursing progress note, dated [DATE] at 8:44 p.m., indicated the resident did not have shortness of breath, his abdomen was soft, non-tender and distended. His blood pressure was 167/98, heart rate was 69, respirations were 18 and oxygen saturation was 97%. The bowel movement documentation, dated [DATE] for 3:00 p.m. to 11:00 p.m. shift, indicated the resident had diarrhea. The size was not documented. The bowel movement documentation, dated [DATE] for 11:00 p.m. to 7:00 a.m. shift, indicated the resident had diarrhea. The size was not documented. A nursing progress note, dated [DATE] 3:10 a.m., indicated Resident 67's respirations were even and non-labored. His abdomen was soft and non-tender. He had bowel sounds in all four quadrants. His blood pressure was 159/74, heart rate was 77, respirations were 16 and oxygen saturation was 95%. A physician's progress note, dated [DATE] at 12:11 p.m., indicated Resident 67 was seen for an admission visit. He was admitted from the hospital on [DATE]. Resident 67 denied any pain and reported having loose stools. The physical exam was limited to decrease the risk of exposure to covid between the nurse practitioner, patient and staff. Resident 67 had no apparent distress, and respirations were clear and unlabored. His abdomen was soft, non-tender, and not distended. Staff were encouraged to contact the office with any concerns. Imodium (an antidiarrheal medication) 2 milligrams (mg) was ordered every six (6) hours as needed for loose stools. A nursing progress note, dated [DATE] at 12:19 p.m., indicated the Nurse Practitioner was there to see the resident and a new order was received for Imodium 2 milligrams every six hours as needed for loose stools.The bowel movement documentation, dated [DATE] for 7:00 a.m. to 3:00 p.m. shift, indicated the resident had diarrhea. The size was not documented. A nursing progress note, dated [DATE] at 4:01 p.m., indicated shortness of breath was noted during a conversation with the resident. The resident indicated this was normal for him. He was educated to notify the nurse with an increase of shortness of breath.The Medication Administration Record (MAR) indicated Imodium 2 mg was administered on [DATE] at 4:45 p.m.A nursing progress note, dated [DATE] at 7:28 p.m., indicated Resident 67 complained of an upset stomach. A standing physician's order (preapproved, written medical protocols used in healthcare settings) for calcium carbonate (Tums) (an antacid used for heartburn) 500 mg two (2) tablets every 4 hours as needed for an upset stomach or indigestion for 48 hours was ordered and the physician was notified by fax. The physician's office did not respond to the fax until [DATE] at 12:27 p.m., to acknowledge the new order entered by the facility.A nursing progress note, dated [DATE] at 9:40 p.m., indicated Resident 67 complained of abdominal pain in all quadrants, indicated he was constipated, and had not had a regular bowel movement in a couple weeks and was only having diarrhea. His abdomen was hard, round, and distended. His bowel sounds were not active. His pain was an eight out of ten. Excessive belching was noted during the assessment. The resident stated he took two (2) Alka-Seltzer (a popular fizzy tablet which provides relief for heartburn and indigestion) with 2 cups of water around 7:30 p.m. This note was faxed to the physician.There was no documentation the on-call physician was contacted directly.The physician's (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	office did not respond to the fax until [DATE] at 12:52 p.m.A nursing progress note, dated [DATE] at 1:58 a.m., indicated Resident 67 was heard yelling out while in bed. He complained of abdominal pain with a lot of belching. His abdomen was distended with hypoactive (decreased) bowel sounds. Resident 67 indicated his stomach had not been hard like this. He was concerned about going back to the hospital and indicated he did not want to go back. His blood pressure was 140/67, heart rate was 94, respirations were 22 and oxygen saturation was 97%. There was no documentation the physician was notified.A nursing progress note, dated [DATE] at 3:03 a.m., indicated a standing physician's order (preapproved, written medical protocols used in healthcare settings) for Miralax 17 grams in 4-8 ounces of beverage of choice every day as needed and Dulcolax suppository rectally every day as needed were entered.A nursing progress note, dated [DATE] at 6:03 a.m., indicated Resident 67 complained of abdominal pain. Nursing leadership was called and indicated to complete a bladder scan to check for urinary retention. The MAR indicated Miralax 17 grams was administered on [DATE] at 11:34 a.m.,A nursing progress note, dated [DATE] at 3:14 p.m., indicated Resident 67 was visibly short of breath and had difficulty finishing sentences. His abdomen was firm and distended. He was holding a basin and spitting clear phlegm with complaints of nausea. His bowel sounds were hypoactive, and his most recent bowel movement was diarrhea yesterday. Resident 67 indicated an increased shortness of breath compared to yesterday. His oxygen saturations were 96% and his pulse was 106. He agreed to be sent to the emergency room. A nursing progress note, dated [DATE] at 3:56 p.m., indicated Resident 67 was notably tachypneic (abnormal rapid, shallow breathing) with shallow respirations. Resident 67's abdomen was distended at baseline, but the resident reported abdominal pain and nausea. Resident 67 was noted with an emesis basin at bedside and phlegm on his chin. Resident 67 reported his last solid bowel movement was three (3) months ago. The resident was admitted with loose stools from hospital on [DATE]. He received an as needed dose of Imodium on [DATE] due to continued loose stools throughout the weekend. Resident 67's bowels were hypoactive in the right upper and lower and the left upper quadrants. No bowel sounds were noted in the left lower quadrant for a three-minute duration. Upon palpation, the abdomen was firm and tight. Resident 67 voiced tenderness upon palpation in all four quadrants. The resident was actively belching during the assessment and reported chest pain but was reporting pain to the upper quadrants as the chest pain site. Write auscultated LS, clear throughout. Resident 67 voiced dyspnea (difficulty in breathing) and feeling bloated. He requested medical intervention to relieve the discomfort but indicated I'd rather not go to the ER. Mottling (a blotchy, lace-like skin discoloration from poor blood flow) was noted to the right lower extremity which was a new onset since admission on [DATE]. Bilateral lower extremities were cool in temperature. The resident was visibly restless. The nurse practitioner was notified of the assessment and resident complaints. Per the nurse practitioner, the resident's CT (computed tomography scan) at the hospital prior to discharge noted a large colonic burden, he was not short of breath during her assessment on [DATE], and this sounded like a change in condition. The resident was to be sent to the hospital for evaluation and treatment. Emergency Medical Services (EMS) arrived in room. His blood pressure was 202/90, heart rate was 106, respirations were 30 and oxygen saturation was 96%. A nursing progress note, dated [DATE] at 10:56 p.m., indicated the resident was admitted to the hospital for a perforated bowel and was undergoing surgery.A nursing progress note, dated [DATE] at 9:03 a.m., indicated the hospital was called for an update and indicated the nurse was with the resident and was unable to give an update at this time. The hospital's unit receptionist indicated the resident was admitted for a small bowel obstruction, perforation, and necrosis (death of cells in an organ).A baseline care plan, dated [DATE], indicated Resident 67 needed assistance with activities of daily living. Interventions included, but were not limited to, notify the physician of any increased pain or discomfort. There were no baseline care plans related to bowels or a diagnosis of constipation. A hospital document, dated [DATE] at 3:29 p.m., indicated Resident 67 arrived at the emergency room with shortness of breath and abdominal pain. He was tachycardic, tachypneic and complained of nausea, vomiting and diarrhea. His abdomen had (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	moderate distention and was hard on palpation. A scan completed at 6:06 p.m., indicated extensive pneumoperitoneum (the presence of free air within the abdominal cavity typically indicating a serious, often life-threatening condition, such as a perforated abdominal organ) consistent with hollow viscus perforation (a life-threatening, full-thickness rupture of the stomach or intestines allowing leakage into the abdominal cavity), extensive small bowel dilation (signifies a significant obstruction) and gastric distention (abnormal stretching or enlargement of the stomach) consistent with obstruction, and pneumatosis of the stomach, duodenum, and small bowel (presence of gas within the walls of these gastrointestinal organs). The ileum (the final and longest section of the small intestine) had collapsed. The diagnosis indicated an acute perforated bowel. Resident 67 was taken into surgery at 7:27 p.m. During the surgery, the hospital was unable to fully remove the duodenum and felt it was best to transfer the patient to a tertiary care center (a specialized, high-level hospital which provides advanced, complex medical treatment).The resident passed away on [DATE].During an interview, on [DATE] at 5:03 p.m., the DON indicated there was no documentation the nurse called the physician and they should have when the resident's condition worsened. The nurse should have called the physician and not have faxed since it was at night. During an interview, on [DATE] at 3:25 p.m., the Nurse Practitioner indicated she seen the resident, on [DATE], and completed an assessment. At that time, he was not complaining of pain, his abdomen was not distended, and he had bowel sounds. The resident was having diarrhea which he had at the hospital, she noticed the resident came with an order for Imodium, which was not put into the facility system, so she added the order to his medications as needed. She was never called and informed of the resident's change in condition. She did receive a fax the next morning and responded as soon as she was given the fax. Her office hours are from 8:00 a.m. to 5:00 p.m. If a fax came in after the office was closed, she would not get the fax until the next day. The faxes were gathered by the office receptionist and dispersed out; this meant it could be a while before she would see the fax. If a facility faxed the office after hours, then she would not know there was a concern until the next day. She did not get a call and responded to the fax as soon as she received it. When she received the fax, she ordered an abdominal x-ray, but she did not think the x-ray was completed because he was sent out before it was obtained. She believed the unit manager did call which was when she ordered the resident to be sent to the hospital. If the resident had a concern or a change in condition, the facility should notify the physician or on-call doctor and not fax. During an interview, on [DATE] at 10:08 a.m., Unit Manager 6 indicated when the resident was admitted his abdomen was round, firm and distended. During the admission skin assessment, they rolled Resident 67 over and he was incontinent of a small loose stool. When the resident was rolled back, he was incontinent with another loose stool. He did not have any discomfort when he was turned but did show some shortness of breath. Unit Manager 6 indicated she was the nurse on-call the weekend Resident 67 had a change in condition. RN 3 called her and informed her Resident 67 had complaints if shortness of breath and abdomen pain. Unit Manager 6 told RN 3 to elevate the head of bed, complete a bladder scan, and follow the normal guidelines of what a physician would order. RN 3 never called her back to follow up, and Unit Manager 6 did not call to check on the resident or follow up on his status. Unit Manager 6 indicated RN 3 should have called her back with an update. Unit Manager 6 also did not call RN 3 back for an update. When she came in the following morning and was completing rounds, she asked RN 7 how the resident was. RN 7 indicated Resident 67 had hypoactive bowel sounds. Unit Manager 6 then completed an assessment, found the resident had hypoactive bowel sounds, and reached out to the physician. It was agreed the resident should be sent out to the hospital.During a telephone interview, on [DATE] at 2:25 p.m., RN 2 indicated she did take care of Resident 67 on [DATE] on the evening shift. RN 2 indicated she worked at the facility on a as needed basis. RN 2 indicated Resident 67 had come out of the bathroom, sat in his recliner, and said he had pain in his abdomen. RN 2 indicated Resident 67 abdomen was distend and hard with no bowel sounds present. RN 2 indicated she passed this information on in report to the oncoming shift.A current facility policy, titled Change in a Resident's Condition or Status, dated February 2021 and received (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	from the DON on [DATE] at 4:55 p.m., indicated .promptly notifies the resident, his or her attending physician.of changes in the resident's medical/mental condition. The nurse will notify the resident' attending physician or physician on call when there has been a(an).significant change.need to alter treatment.need to transfer the resident to a hospital.A significant change of condition is a major decline.that.will not normally resolve itself.impacts more than one area of the resident's health.The immediate jeopardy, that began on [DATE], was removed on [DATE], when the facility reviewed the policies and procedures regarding physician notification of change, the Senior Regional Director of Clinical Services reviewed the process for internal communication of resident condition change to nursing management and educated nursing management on physician notification, audits of all residents and of physician notification of condition changes were completed, staff received education on the requirements for physician notification of a change in a residents condition.3.1-5(a)(1)3.1-5(a)(2)3.1-5(a)(3)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to ensure the resident and/or resident's representative was provided in writing the facility's bed hold policy upon transfer for 3 of 3 residents reviewed for hospitalization. (Resident 64, 67 and 3)Findings include:1. The clinical record for Resident 64 was reviewed on 1/15/26 at 9:57 a.m. The diagnoses included, but were not limited to, myocardial infarction, acute pulmonary edema, supraventricular tachycardia, respiratory failure with hypoxia, combined systolic (congestive) and diastolic (congestive) heart failure, and type 2 diabetes mellitus. A nursing progress note, dated 9/21/25 at 10:45 p.m., indicated the resident was sent to the emergency room for increased shortness of breath. A nursing progress note, dated 9/25/25 at 4:18 p.m., indicated the resident returned to the facility after a hospital stay for shortness of breath and exacerbation of congestive heart failure. There was no documentation in the electronic medical record to indicate the resident or resident's representative was provided with information in writing of the facility's bed hold policy, including reserve bed payment. 2. The clinical record for Resident 67 was reviewed on 1/16/26 at 11:00 a.m. The diagnoses included, but were not limited to, constipation, right fibular fracture, hypertension with heart failure, and chronic anticoagulation. A nursing progress note, dated 10/21/25 at 3:56 p.m., indicated the resident was sent to the emergency room for shortness of breath, dyspnea, pain, and nausea. A nursing progress note, dated 10/21/25 at 10:56 p.m., indicated the resident was admitted to the hospital with a perforated bowel. There was no documentation in the electronic medical record to indicate the resident or resident's representative was provided with information in writing of the facility's bed hold policy, including reserve bed payment. 3. The clinical record for Resident 3 was reviewed on 1/14/26 at 3:49 p.m. The diagnoses included, but were not limited to, Parkinson's disease, dementia, morbid obesity, hypertensive chronic kidney disease, and personal history of Covid-19. A nursing progress note, dated 11/12/25 at 6:06 p.m., indicated the resident was sent to the hospital due to rectal bleeding. A nursing progress note, dated 11/14/25 at 6:28 p.m., indicated the resident was returned to the facility, at 5:50 p.m., and had been treated for hypernatremia and fluid overload, which had been resolved. A nursing progress note, dated 11/21/25 at 7:34 p.m., indicated the resident was sent to the emergency room for an ileus pattern (sign on imaging such as an x-ray and symptoms of a paralytic ileus, where the intestines temporarily stop moving) which was seen on a previous scan. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing progress note, dated 11/21/25 at 10:34 p.m., indicated the resident was being admitted to the hospital for a gastrointestinal bleed of unknown origin. There was no documentation in the electronic medical record to indicate the resident or resident's representative was provided with information in writing of the facility's bed hold policy, including reserve bed payment. During an interview, on 1/20/26 at 2:23 p.m., the Executive Director (ED) indicated the bed hold policy and reserve bed cost were not given to the resident's representative in writing. During an interview, on 1/20/26 at 3:09 p.m., Unit Manager 8 indicated the bed hold policy form was to be completed with all transfers. The bed hold policy was copied after it was completed and sent with a resident when transferred. Representatives of the residents were to be contacted to see if they would like to hold the bed or not. A current facility policy, titled Transfer or Discharge, Facility Initiated, dated as last revised 10/2022 and received from the Director of Nursing on 1/20/26 at 4:44 p.m., indicated .The resident and representative are notified in writing of the following information.The Notice of Facility Bed-Hold and policies. 3.1-12(a)(6)(A)(i) 3.1-12(a)(6)(A)(ii) 3.1-12(a)(6)(A)(iii)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on interview and record review, the facility failed to ensure a PASARR (Preadmission Screening and Resident Review) was completed when the resident had a new mental health diagnosis and was prescribed an antipsychotic medication for 1 of 3 residents reviewed for PASARR. (Residents 5)Findings include:The clinical record for Resident 5 was reviewed on 1/15/26 at 12:27 p.m. The diagnoses included, but were not limited to, depressive disorder, anxiety disorder, congestive heart failure, dementia, and hypertension.A physician's order, dated 11/05/25, indicated to administer Rexulti (an atypical antipsychotic medication) 0.5 mg (milligram) one tablet in the morning related to anxiety disorder. A physician's order, dated 11/05/25, indicated to administer buspirone (an anxiolytic medication) 0.5 mg (milligram) one tablet two times a day. A care plan, dated as revised 12/18/25, indicated the resident was at risk for anxious mood as evidenced by becoming fidgety, restless, tearful, anxious, and agitated. The interventions included, but were not limited to, administering medication as ordered.A PASARR level I screen related to the diagnosis of anxiety disorder, and the new medication was not completed until 1/16/26.During an interview, on 1/21/26 at 10:49 a.m., the Social Service Director (SSD) 5 indicated when a resident had a new psychotic medication or a new mental health diagnosis added, a new Level I needed to be completed. The resident did not have a new Level I completed until 1/16/26. A current facility policy, titled Psychotropic Medication Use, dated as revised 7/2022 and received by the Administrator on 1/20/25 at 3:20 p.m., indicated .A psychotropic medication is a medication that affects brain activity associated with mental processes and behavior A current facility policy, titled Behavioral Assessment, Intervention and Monitoring, dated as revised on 7/2020 and received by the Administrator on 1/20/25 at 3:20 p.m., indicated .A psychotropic medication is a medication that affects brain activity associated with mental processes and behavior .psychotropic medication.3.1-16(d)(1)(A)3.1-16(d)(1)(B)

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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 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. Based on interview and record review, the facility failed to ensure daily weights were obtained as ordered by the physician for 1 of 1 resident reviewed for quality of care. (Resident 9)Findings include: The clinical record for Resident 9 was reviewed on 1/15/26 at 11:33 a.m. The diagnoses included, but were not limited to, congestive heart failure (CHF), dementia, diabetes mellitus, atrial fibrillation, and anxiety disorder.A physician's order, dated 6/28/25, indicated to obtain a post void daily weight in the morning, before breakfast, while wearing pajamas, and to notify the physician if the resident had a two (2) pound weight gain in 24 hours or a five (5) pound or more weight gain in one (1) week. a. The Medication Administration Record (MAR), dated 10/1/25 to 10/31/25, indicated the daily weights were not documented on 10/10/25, 10/18/25, 10/22/25, and 10/29/25.On 10/27/25, Resident 9 had a weight gain of 2.8 pounds.b. The MAR, dated 11/1/25 to 11/30/25, indicated the daily weights were not documented on 11/5/25, 11/7/25, 11/12/25, and 11/25/25.On 11/28/25, Resident 9 had a weight gain of 2.5 pounds.On 11/30/25, Resident 9 had a weight gain of 3.5 pounds. c. The MAR, dated 12/1/25 to 12/31/25, indicated the daily weights were not documented on 12/1/25, 12/8/25, 12/9/25, 12/10/25, 12/11/25, 12/13/25, 12/14/25, 12/16/25, 12/19/25, 12/22/25, 12/23/25, 12/25/25, 12/26/25, and 12/28/25.A care plan related to congestive heart failure was not located in the electronic medical record.During an interview, on 1/21/26 at 12:59 a.m., CNA 9 indicated the nurse told the CNAs which resident needed a daily weight. When the weight was obtained, the CNA told the nurse, and the nurse charted the weight. During an interview, on 1/21/26 at 1:01 p.m., LPN 10 indicated if a resident had an order for a daily weight, the nurse added the resident's name to the CNAs assignment clipboard. Once the CNA obtained the weight, the nurse added the weight to the electronic health record. When a resident had a diagnosis of congestive heart failure, it was important to obtain the weight, and if the resident had a greater than two (2) pound gain in a day the physician should be notified. A current facility policy, titled Daily Weight Monitoring for Residents with Physician Orders, dated 3/13/25 and received from the Director of Nursing on 1/21/26 at 4:15 p.m., indicated .To ensure accurate, consistent monitoring of resident weights as ordered by the physician, and to promptly identify and report clinically significant weight changes .Weights will be obtained upon arising .Void prior to weighing (when able), Be weighed before first meal .Be weighed before dressing, or in consistent light clothing per facility practice .The physician (or designated provider) must be notified of any weight variances per physician orders .Nursing staff will follow physician orders for further assessment, monitoring, or interventions .All notifications and new orders will be documented in the medical record .Nursing staff are responsible for obtaining and documenting weights accurately. Charge nurse or designee is responsible for ensuring physician notification when parameters are met .All staff are expected to adhere to this policy 3.1-37(a)