

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>ASL510403</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/22/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WESTMINSTER VILLAGE AL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2025 E LINCOLN ST BLOOMINGTON, IL 61701</b>
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comment  Annual Licensure survey and original investigation of FRI IL 183762.  295.4010 e) cited. for both Annual and FRI	A 000		
A4010	Section 295.4010 Service Plan  This Regulation is not met as evidenced by: Section 295.4010 Service Plan  e) The service plan shall be reviewed and revised if necessary immediately after a significant change in the resident's physical, cognitive, or functional condition.  VIOLATION  Based on record review and interviews, the establishment failed to revise the service plan as needed for two of six sampled residents. (R1 and R4)  Findings include:  1) R4's Physician's orders note that R4 currently has a venous ulcer on his right lower leg that started on 10/20/24. R4 receives wound care and dressing changes three times a week.  R4's current service plan is dated 6/10/24 and fails to address the wound on his right lower leg. There is nothing mentioned on the service plan regarding any skin issues or risks for skin breakdown.	A4010		

Illinois Department of Public Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>ASL510403</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/22/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WESTMINSTER VILLAGE AL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2025 E LINCOLN ST BLOOMINGTON, IL 61701</b>
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4010	<p>Continued From page 1</p> <p>On 1/22/25 at 11:04 A.M., E1 (Director) stated that R4 had an venous ulcer on that right lower leg that had healed in April 2024 and then opened up again at the of October 2024. E1 confirmed that R1's venous was never addressed on his service plan.</p> <p>2) R1's progress notes note that R1 had fallen in her kitchen on 12/27/24 but suffered no injuries. R1's progress note on 1/4/25 notes that R1 had a fall in her apartment and was sent to the local hospital for treatment of a subarachnoid hematoma.</p> <p>R1's current service plan notes that R1 was admitted to the facility on 11/20/24. R1's service plan is dated 11/20/24 and has not been revised after R1's falls in order to implement interventions to help reduce the risk of falls.</p>	A4010		