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	04/10/2024

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

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to assess for the ability to self administer medications for three (R37, R97, R101) of three residents reviewed for self administration of medication in the sample list of 31. Findings include: 1.) On 4/08/24 at 10:04 AM there were bottles of saline nasal spray and artificial tears at R37's bedside and in R37's bathroom. R37's Minimum Data Set, dated [DATE] documents R37 has moderate cognitive impairment. R37's Order Summary dated 4/9/24 does not include orders for saline nasal spray or artificial tears. R37's medical record does not document orders to self administer medications or that medications may be kept at the bedside. There is no assessment of R37's ability to self administer medications. 2.) On 4/08/24 at 10:24 AM there were two tubes of Diclofenac (topical pain reliever) 1% on R97's night stand. R97 stated R97 was unsure about the medication use. 4/9/24 at 11:31 AM the Diclofenac tubes were on R97's night stand. R97's Brief Interview for Mental Status (BIMS) Score dated 4/4/24 documents a score of 4, indicating severe cognitive impairment. R97's Order Summary dated 4/9/24 does not include an order for Diclofenac. R97's medical record does not document orders to self administer medications or that medications may be kept at the bedside. There is no assessment of R97's ability to self administer medications. 3.) On 4/08/24 at 10:21 AM there was a bottle of Flonase and three tablets of medication in a medication cup on R101's overbed table. R101 stated the tablets were Tums that R101 takes once per day. R101's BIMS dated 4/4/24 documents a score of 12, indicating moderate cognitive impairment. R101's medical record does not include orders to self administer medications or that medications can be kept at the bedside. There is no assessment of R101's ability to self administer medications. On 4/09/24 at 11:46 AM V7 Registered Nurse stated residents may keep medications at the bedside if approved by the physician and there is an order to keep the medication at bedside. V7 stated V7 just got an order today for R101 to keep Tums in R101's room. V7 confirmed R101 does not have an order to keep Flonase at the bedside or for self administration. V7 confirmed R97 does not have an order for Diclofenac. V7 confirmed R37 does not have orders for saline nasal spray and artificial tears. (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

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	04/10/2024

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/09/24 at 12:36 PM V2 Director of Nursing stated residents should have an assessment for the ability to keep medications at the bedside and orders for self administration of medications. The facility's Bedside Medication Storage policy dated 10/25/14 documents residents are allowed to self administer medications once assessed and deemed appropriate, there is a written physician order, and the medications must be stored in a manner that prevents access by other residents. This policy documents medications may be kept at the bedside as indicated on the Medication Administration Record and the care plan. This policy documents nurses and nurse aides should report unauthorized medications found at the bedside and the medications should be given to the nurse to return to the resident's representative.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review the facility failed to investigate an injury of unknown origin for one (R16) of three residents reviewed for accidents in the sample list of 31. Findings include: The facility's Abuse Policy dated June 2023 documents allegations or suspicions of abuse, neglect, mistreatment, misappropriation of resident property, or injuries of unknown origin will be reported to the facility's Administrator, Director of Nursing, or other designated staff. This policy documents injuries are considered of unknown source when the source of the injury was not observed or could not be explained by the resident and is suspicious due to the extent or location of the injury or number of injuries at one time or over time. This policy documents injuries of unknown source will be investigated within two hours of receipt of notification and the results of the investigation will be reported to the Illinois Department of Public Health within five days. R16's Nursing Note dated 3/14/2024 at 6:32 AM documents R16 fell and required the use of a full mechanical lift to transfer R16 off of the floor since R16 was unable to stand. R16's Nursing Note dated 3/15/24 at 2:22 PM documents R16 had congestion and coughing. R16's Nursing Notes dated 3/16/24 at 3:30 AM and 10: 39 PM document R16 complained of right flank and right back pain. On 3/17/24 R16 was transferred to the hospital for complaints of pain and congestion and on 3/17/24 the facility was notified at 10:48 AM that R16 had diagnoses of right rib fractures and would be returning to the facility. R16's Order Summary dated 4/9/24 documents a diagnoses of multiple rib fractures of right side. There is no documentation that the cause of R16's rib fractures was identified or that the fractures were investigated. On 4/09/24 at 12:13 PM V2 Director of Nursing (DON) and V3 Assistant DON stated they were unaware that R16 had rib fractures. V2 stated R16 went to the hospital on a Saturday and the nurse did not notify V2 of R16's rib fractures, and V2 should have been notified. V2 confirmed this injury would have been investigated if V2 was notified. V2 and V3 were uncertain as to the cause of R16's rib fractures. V3 stated V3 did not think it was related to R16's fall since R16 had a chest x-ray on 3/14/24 after the fall, and it did not identify any fractures. V3 stated V3 questions whether the rib fractures were due to R16 coughing as R16 had respiratory symptoms when R16 fell (3/14/24). On 4/9/24 at 4:00 PM V1 Administrator stated V1 is now doing an investigation into R16's rib fractures.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to conduct careplan meetings for one of one residents (R21) reviewed for careplan meetings in the sample list of 31. Findings include: On 4/08/24 at 12:41 PM R21 stated the facility does not have care plan meetings with R21 or R21's family. R21's medical record documents she admitted to the facility on [DATE] and Minimum Data Sets were completed on 12/18/23 and 2/16/24. On 4/09/24 at 10:25 AM, V8 Social Services Director (SSD) stated R21 last had a care plan meeting on 12/28/23 and residents have a care plan meeting every quarter. On 4/9/24 at 11:30 AM, V9 Assistant SSD stated V8 was still working on getting R21's care plan information and R21's care plan meeting was scheduled today for 4/11/24. On 4/9/24 at 2:35 PM, V10 Minimum Data Set (MDS)/Care Plan Coordinator stated R21 has not had a careplan meeting since 12/28/23 and V10 follows the MDS schedule to set up care plan meetings every 90 days. V10 stated V10 has 95 residents to keep track of and it (R21's care plan meeting) got missed. V10 stated as soon as V10 realized R21's careplan meeting was missed V10 called today to schedule a meeting with R21's family on 4/11/24 at 3:00pm. The facility policy titled Care Plans- Comprehensive revised October 2010 documents the Care Planning/ Interdisciplinary Team is responsible for the review and updating of careplans: when there has been a significant change in the residents condition, when desired outcome is not met and when the resident has been readmitted to the facility from a hospital stay; and at least quarterly. The policy further states the resident has the right to refuse to participate in the development of his/her care plan and medical and nursing treatments. When such refusals are made, appropriate documentation will be entered into the residents clinical records.

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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, interview, and record review the facility failed to document and follow up on a change in condition for one (R28) of 14 residents reviewed for change in condition in the sample list of 31. Findings include: On 4/08/24 at 10:54 AM R28 stated R28 has a right elbow goose egg and swelling that started about three weeks ago and R28 has told the nurses about it. R28 stated the nurses told R28 that R28 needed to see the doctor, but R28 has not yet seen R28's physician to evaluate R28's elbow. R28's right elbow had swelling approximately the size of a golf ball. R28's Minimum Data Set, dated [DATE] documents R28 is cognitively intact. There is no documentation in R28's medical record of R28's right elbow swelling or that R28 has been evaluated for this complaint. On 4/09/24 at 3:19 PM V25 Registered Nurse stated V25 noticed R28's swollen right elbow last Thursday (4/4/24) when R28 complained about it. V25 described the swelling as soft fluid, and similar to gout. V25 stated V25 left a note for R28's physician in the physician's folder, and the physician rounds on Fridays. V25 stated V25 was unsure if R28's physician saw R28 on 4/5/24 and thought R28 was seen by the physician today. V25 stated there is a place to document physician notification in the progress notes and V25 did not document a description of R28's right elbow or R28's complaint in R28's medical record. On 4/10/24 at 1:31 PM V2 Director of Nursing stated if it isn't urgent, the nurse can put a note in the physician's folder. V2 stated any resident changes the nurses find should be documented in a progress note. At 2:30 PM V2 stated V2 just spoke with V28 Physician regarding R28's right elbow, and V28 order an elastic bandage wrap to be applied and V28 will evaluate R28 during V28's next visit. V2 confirmed there is no documentation that R28's right elbow was assessed or reported to V28. The facility's Change in a Resident's Condition or Status dated February 2021 documents changes in a resident's condition including a need to alter treatment significantly and for problems that will not normally resolve without intervention will be reported to the resident's physician and the nurse will document information related to the change in condition in the resident's medical record.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to complete a comprehensive wound assessment for new pressure injuries for two residents (R149, R150) of three residents reviewed for pressure ulcers in a sample list of 31. Findings Include: 1. R150's Nursing admission History dated 3/15/24 at 6:08PM documents R150 was cognitively intact and required staff assistance for transfer and Activities of Daily Living (ADLs) and R150's skin was intact. R150's Minimum Data Set (MDS) dated [DATE] documents R150 has two Stage II pressure Ulcers. R150's Order Summary printed 4/10/24 at 4:03PM includes a physician's order originating 3/27/24 for Right buttock open area: Cleanse with Normal Saline, apply hydrocolloid every evening shift every 3 day(s). This order summary also documents a physician's order originating 4/9/24 for Left buttock open area: Cleanse with NS, apply skin prep around wound bed, apply hydrocolloid every evening shift every 3 day(s). There is no comprehensive wound assessment documented for R150. On 4/8/24 at 9:40AM, R150 was observed sitting in a wheelchair in her room. There was a cushion in the wheelchair under R150. R150 stated My bottom is getting more sore all the time. It hurts, but they (Staff) leave me in this wheelchair staring at the wall. That recliner over there (R150 gestured to the recliner across the room) would be more comfortable, and I could move around better, but they don't take the time to help me move to it. 2. R149's Minimum Data Set (MDS) dated [DATE] documents R149 as cognitively intact, requiring substantial staff assistance for transfer and toileting, and at risk for pressure ulcers, but had no pressure ulcers at the time of the assessment. R149's Treatment Administration Record for 4/1/24 through 4/30/24 includes a treatment initiated 4/2/24 for R (right) buttock pressure area: Cleanse with NS (normal saline), apply skin prep around wound bed, apply hydrocolloid every 3 days and PRN (as needed) every night shift every 3 day(s) There is no comprehensive wound assessment documented for R149. R149's Care Plan was not updated to include the pressure ulcer until 4/9/24. The facility policy Instructions for Implementation of Wound Protocol updated 3/2024 does not identify staff responsible for initial wound assessments. On 4/8/24 at 1:00PM V3, Assistant Director of Nursing reported the facility had only one active pressure ulcer. The resident V3 identified was R33. On 4/10/24 at 2:00PM, V10, Care Plan Coordinator stated I do the full wound assessment weekly but I have only been made aware of (R149, R150) since 4/9/24. V10 verified there was no documentation of appearance of periwound, wound bed, presence of drainage or pain to the open area (for R149 and (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R150).

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview, and record review the facility failed to ensure oxygen canisters were secure (R101), thoroughly investigate falls, and care plan and implement fall interventions (R5). R101 and R5 are two of three residents reviewed for accidents in the sample list of 31. Findings include: 1.) On 4/08/24 at 10:19 AM and 1:42 PM there were two unsecured, free standing, Oxygen cylinders at the end of the hall near R101's doorway. On 4/08/24 at 2:48 PM V2 Director of Nursing stated we have a room to store oxygen, we have liquid oxygen, and sometimes hospice delivers oxygen cylinders to the facility without notifying us. V2 stated oxygen cylinders should be secured. V2 observed the unsecured oxygen cylinders near R101's room and confirmed they were not stored appropriately. V2 stated the oxygen cylinders belong to R101 who was recently admitted to hospice, and hospice must have delivered the oxygen. V2 stated the cylinders will need to be placed in the oxygen storage room. The facility's Oxygen Therapy policy dated March 2024 documents Oxygen will be used and stored in a manner to ensure resident and staff safety. 2.) On 4/08/24 at 10:34 AM R5 was lying in bed and the pressure sensor for R5's bed alarm was not connected to an alarming device. There was a pressure sensor pad in R5's wheelchair that was connected to an alarming device. At 10:38 AM V26 Certified Nursing Assistant (CNA) stated R5 does attempt to self transfer at times. At 12:17 PM R5 was sitting in a wheelchair in the dining room, and there was a chair alarm in place. At 3:44 PM V27 CNA assisted R5 to sit on the side of the bed. R5's bed pressure sensor was not connected to an alarming device. V27 stated R5 was lying in bed when V27 arrived for second shift and staff should be using the alarming device connected to R5's chair pressure sensor to connect to the pressure sensor in R5's bed. On 4/09/24 at 10:48 AM R5 was sitting in the wheelchair in the dining room and the pressure sensor in R5's wheelchair was not connected to an alarming device. On 4/09/24 at 10:58 AM V7 Registered Nurse stated R5 uses a chair and bed alarm and the CNAs are responsible for checking the functioning of the alarms. V7 confirmed R5's pressure sensor was not connected to an alarming device, and should be. On 4/09/24 at 11:02 AM V11 CNA stated fall interventions including alarms are documented as part of the CNA tasks in the resident's electronic medical record. V11 stated R5 has used bed and chair alarms since R5 admitted to the facility. R5's Minimum Data Set (MDS) dated [DATE] documents R5 requires substantial/maximal assistance of staff for transfers and is occasionally incontinent of urine. R5's MDS dated [DATE] documents R5 has moderate cognitive impairment, is occasionally incontinent of urine, and requires substantial/maximal assistance for toileting and partial/moderate assistance for transfers. R5's Care Plan dated 1/15/24 documents R5 admitted to the facility on [DATE], is high risk for falls, and does not include interventions to use bed and chair alarms. Bed and chair alarms are not listed in the tasks section of R5's electronic medical record. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R5's fall investigation documents R5 had an unwitnessed fall and was found on the floor next to R5's bed on 11/27/23 at 4:12 PM. The investigation documents R5 stated R5 was attempting get to R5's walker to walk in room and check clothes in R5's dresser, and this is documented as the root cause of the fall. R5's fall investigation documents R5 had an unwitnessed fall in R5's room on 12/18/23 at 3:44 PM, and was found by an unidentified CNA on the floor in front of R5's wheelchair. R5 was unable to explain what happened. The documented root cause of the fall is R5 gets restless in the afternoon and wants to go somewhere. R5's fall investigation documents R5 had a witnessed fall out of bed on 12/25/23 at 1:19 AM and R5 was unable to give details of the fall. The documented root cause of the fall is R5 was incontinent of urine and wanted to go to the bathroom. These fall investigations are not thorough and do not document the last time R5 was checked on/R5's activity prior to the fall, when R5 was last toileted prior to the fall, or if there were any alarming devices in place during R5's falls. There is no documentation that any staff were interviewed regarding these falls. On 4/10/24 at 10:06 AM V3 Assistant Director of Nursing provided R5's fall investigations and confirmed all documentation was provided. V3 stated V3 only interviews the nurse who documents the fall in the nursing notes. At 11:23 AM V3 reviewed R5's fall investigations and stated they could be better and that is something V3 is working on. V3 confirmed there is no documentation that staff were interviewed to determine the last time R5 was checked on/toileted, activity prior to the fall, or if alarming devices were implemented. V3 stated R5 is incontinent but also uses the toilet, and staff should toilet before/after meals and every two hours. V3 stated R5's 11/27/24 fall intervention was 15 minute checks, 12/25/23 fall intervention was bed positioned low to floor, and 12/18/23 fall intervention was to determine unmet needs such as hunger/thirst. V3 stated the bed and chair alarms were implemented as interventions when R5 admitted and should be documented as part of R5's care plan and tasks in order for the CNAs to see the interventions. The facility's Falls and Fall Risk Management policy dated 1/2/24 documents staff will identify causes and resident centered interventions to try to prevent falls and minimize complications related to falls, and alarm use efficacy will be monitored. The facility's Clinical Protocol for Falls dated 1/2/24 documents nursing staff will evaluate and document falls, and lists examples such as when and where they happen and any observation of the event.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review the facility failed to perform complete urinary catheter care, failed to prevent cross contamination during urinary catheter care, and failed to maintain the urinary collection bag in a dignity bag and off the floor for three residents (R33, R31, R97) of four residents reviewed for catheter care in a sample list of 31 residents. Findings Include: 1. R33's Physician's Orders for 4/1/24 to 4/30/24 document a Physician's order for urinary catheter care daily and as needed. On 4/10/24 at 11:00 AM V22, Certified Nurse's Aide (CNA) and V23 Certified Nurse's Aide (CNA) proceeded to perform catheter care for R33. R33 was wearing a pull up style incontinence garment. R33 had a bowel movement prior to care. V23 retracted R33's foreskin and cleaned R33's penis from tip to base. V23 cleansed the catheter tubing from insertion site downward. Both CNAs turned R33 to the left side. V23 removed the incontinence brief and cleaned R33's gluteal cleft and buttocks. Both CNA's placed a clean incontinence brief on R33 and covered R33. Neither CNA checked R33's creases between the thighs and the genitals for soiling or cleansed that area. V23 stated I should have washed the cracks between (R33's) thighs.2.) R31's Care Plan dated 2/19/24 documents antibiotics were ordered to treat a Urinary Tract Infection. This Care Plan documents R31 has an indwelling urinary catheter due to urinary retention and includes interventions for contact isolation due to colonization of MRSA (Methicillin Resistant Staphylococcus Aureus (multidrug resistant organism), and to provide catheter care every shift. On 4/09/24 at 1:26 PM V15 and V11 Certified Nursing Assistants (CNAs) entered R31's room. V15 applied gloves, removed R31's shoes, and used the same gloves to clean R31's urinary catheter tubing. V15 did not retract R31's foreskin or clean R31's penis during R31's catheter care. On 4/10/24 at 1:31 PM V2 Director of Nursing/Infection Preventionist stated the foreskin should be retracted and the penis cleansed during urinary catheter care. V2 stated V15 should have changed V15's gloves after removing R31's shoes and prior to providing catheter care. 3.) R97's Care Plan dated 4/5/24 documents R97 has an indwelling urinary catheter and includes an intervention to use a dignity cover over the collection bag. On 4/08/24 at 11:46 AM R97 was sitting in the wheelchair in the dining room. R97's urinary catheter collection bag was uncovered and hanging underneath of R97's wheelchair. The base of the bag was touching the floor and did not contain a dignity cover. At 12:40 PM R97's urinary collection bag was touching the floor when V24 CNA transported R97 out of the dining room. On 4/10/24 at 1:31 PM V2 stated urinary collection bags should be in a privacy bag for dignity and infection control, to prevent the bag from touching the floor. The facility's Nursing Patient Care Policy & Procedure dated 2/14/24 documents to perform hand hygiene, apply gloves, cleanse the suprapubic and pubic area, and for uncircumcised males retract foreskin and cleanse in a circular motion from the urinary meatus down to the shaft of the penis. Keep (urinary) drainage bag off the floor.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide feeding assistance, implement nutritional recommendations, evaluate nutritional supplement intakes, notify the physician of significant weight loss, and ensure significant weight loss was evaluated by a dietitian for two (R5, R21) of two residents reviewed for nutrition in the sample list of 31. These failures resulted in R5 experiencing a severe weight loss of 16.65% (percent) in six months and R21 experiencing a 15.6% severe weight loss in two months. Findings include: The facility's Nutrition (Impaired)/Unplanned Weight Loss- Clinical Protocol dated September 2017 documents the physician will be notified of significant weight loss including persistent changes in baseline appetite/food intake, and the physician will help identify medical conditions that may cause the weight change and will consider if any additional diagnostic testing is indicated. This policy documents the staff and physician will identify and implement appropriate interventions to address weight loss and will monitor the resident's nutritional status including response to interventions. 1.) R5's Minimum Data Set (MDS) dated [DATE] documents R5 has moderate cognitive impairment, requires setup assistance for meals, and has had a significant weight loss of 5% or more in one month or 10% or more in six months that was not prescribed. R5's Weight Log documents R5's weight as follows: 107.1 lbs (pounds) on admission of 9/7/23 105.8 lbs on 9/17/23 101.5 lbs on 10/1/23 (5.2% loss since 9/7/23) 100.5 lbs on 11/1/23 96.0 lbs on 12/1/23 (10.4% loss since 9/7/23) 95.2 on 1/1/24 (11.1% loss since 9/7/23) 92.6 lbs on 2/1/24 (13.5% loss since 9/7/23) 90.5 lbs on 3/1/24 (15.5% loss since 9/7/23) 85.7 lbs on 4/1/24 (5.3% since 3/1/23) 84.6 lbs on 4/3/24 (16.65% since 10/1/23) R5's Care Plan dated 1/15/24 documents an intervention for supervision/touching assistance for eating with the helper providing verbal cues/touching/steadying trunk. R5's Care Plan dated 9/20/23 documents R5 is at risk for malnutrition, is underweight, and has a Body Mass Index (BMI) of less than 19. This care plan includes interventions to assist with feeding as needed, encourage oral intake, (continued on next page)

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

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F 0692 Level of Harm - Actual harm Residents Affected - Few	offer snacks between meals and document acceptance, nutritional supplement 120 ml (milliliters) three times daily (TID), frozen nutritional supplement PRN (as needed), obtain weights as ordered, and notify the physician of significant weight loss. There is no documentation in R5's medical record that any new nutritional interventions were implemented after 12/18/23. R5's Meal Intake with date range 3/12/24-4/10/24 documents of the 88 meals 11 meals had 0-25% consumed, 28 meals had 26-50% consumed, and two meals were refused. R5's March and April Medication Administration Records (MARs) document to administer the frozen nutritional supplement PRN and does not document that R5 was offered this supplement. R5's Nutrition/Dietary Notes document R5 was evaluated by V20 Registered Dietitian (RD) on 9/13/23, 12/18/23, and 3/15/24. On 9/13/23 V20 recommended adding nutritional supplement 60 ml three times daily and a frozen nutritional supplement PRN. On 12/18/23 V20 documented R5's weight loss is likely secondary to decreased appetite and oral intake, and behaviors of refusing meals, supplements, and medications. V20 recommended to increase the nutritional supplement to 120 ml three times daily, continue with the frozen nutritional supplement PRN, and R5's family will encourage the frozen nutritional supplement in the afternoon. On 3/15/24 V20 documented R5 requires varying levels of feeding assistance including independent, supervision, and fully dependence on staff. V20 did not document new recommendations to address R5's continued significant weight loss. There is no documentation that R5's weight is monitored more frequently than on a monthly basis, R5's October significant weight loss was evaluated by V20 Registered Dietitian or that any new nutritional interventions were implemented after 9/13/23 until 12/18/23. There is no documentation that V20 evaluated R5 after 12/18/23 until 3/15/24. There is no documentation that R5's trending significant weight loss that began on 10/1/23 was reported to or evaluated by a physician. On 4/08/24 at 11:53 AM R5 was sitting in the dining room and had not taken any bites of food from the meal which consisted barbecued ground beef sandwich, mashed potatoes with gravy, peas, and lemon dessert bar. No staff was sitting with R5 to provide cueing or assistance. At 12:14 PM V24 Certified Nursing Assistant sat next to R5 and offered assistance/cueing. R5 only accepted a few bites of food from V24. V24 asked R5 if R5 wanted something else to eat and R5 did not respond. V24 did not offer R5 a frozen nutritional supplement. At 12:19 PM V13 Registered Nurse (RN) sat down beside R5 and fed R5 bites of food. At 12:26 PM R5 ate half of R5's sandwich and 75% of the mashed potatoes with V13's assistance. On 4/9/24 at 11:30 AM R5's Family (V12) stated R5's family visit often at meal time to feed R5, as R5 eats better when someone assists R5 with meals. V12 stated R5's family are concerned that staff may not be assisting R5 with meals. R5 ate 75% of the noon meal on 4/9/24, with V12's assistance. On 4/10/24 at 11:40 AM R5 was sitting in the dining room with a small cup of the nutritional supplement and a plate of ground meat, green beans and mashed potatoes with gravy. R5 was able to use the fork to take bites of mashed potatoes, but had difficulty getting bites of the ground meat and green beans as they fell off of R5's fork. No staff was sitting with R5 to provide cueing or assistance. V11 Certified Nursing Assistant (CNA) was asked if any residents require eating assistance in this dining room (where R5 was eating). V11 stated there are no residents who require help with eating on a consistent basis. At 12:00 PM V11 began giving R5 bites of food, after it was pointed out that R5 was having difficulty eating. At 12:30 PM V11 was asked how much of the noon meal R5 consumed and V11 stated I don't know, I walked away. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 4/10/24 at 2:15 PM V14 (R5's Family) stated R5 typically does better if someone assists R5 with meals and R5 eats better with a spoon instead of a fork. V14 stated R5 does not show interest in the frozen nutritional supplement and asked if there were alternative options to this supplement and if R5 could be weighed weekly instead of monthly. On 4/10/24 at 10:18 AM V2 DON (Director of Nursing) stated V20 RD reviews the weights monthly and V20's recommendations are given to the physician to review, which is how the physician is notified of weight loss. V2 stated the frozen nutritional supplement is given by the nurses and signed out on the MAR when given. At 12:55 PM V2 confirmed R5's weight loss has not been reported to or evaluated by a physician. At 1:31 PM V2 stated staff should offer assistance if R5 is not eating or having difficulty eating, but R5 does not always accept assistance. V2 stated maybe we should schedule R5's frozen nutritional supplement to be given routinely. On 4/10/24 at 11:57 AM V20 RD stated if there isn't a nutrition note, then V20 likely did not see R5 during the months that were not documented in R5's dietary notes (October 2023, November 2023, January 2024, and February 2024). V20 stated V20 runs a weight report monthly to see if there are any significant weight changes and then V20 follows up on those weight changes. V20 stated V20 originally spoke with R5's family and they were going to give R5's frozen nutritional supplement in the afternoons, and R5 refuses R5's supplements at times. V20 confirmed staff should offer the frozen nutritional supplement at meals if R5 has poor appetite or isn't eating, and this supplement could prevent further weight loss. V20 stated V20 talks with the nurses to determine if supplements are given and accepted. V20 stated the nutritional supplement 60 ml TID was ordered in September 2023 and increased in December 2023 to 120 ml TID. V20 confirmed there were no other nutritional interventions implemented between September 2023 and December 2023. V20 stated V20 gives V20's recommendation forms to the nurses to follow up with the physician. V20 stated a big part of R5's weight loss is R5's poor intakes and poor appetite, and confirmed staff should offer assistance when R5 is having difficulty eating or poor appetite. V20 confirmed if staff do not assist R5 when needed, this could contribute to R5's weight loss. On 4/10/24 at 12:55 PM V20 confirmed there were no new nutritional interventions recommended or implemented for R5 after 12/18/23. 2.) R21's Physician Order dated 3/9/24 documents to administer (nutritional supplement) twice daily (does not specify Original or Plus version) and may substitute with (comparable alternate nutritional supplement) 120 ml TID. R21's March and April 2024 MARs document administration of this order, but do not document if or when the alternate supplement was given or the amount of (nutritional supplement) given. R21's Weight Log documents R21's weight as follows: 81.5 lbs (admission weight) on 12/12/23 78.4 lbs on 12/31/23 75.6 lbs on 1/1/24 (7.2% loss since 12/12/23) 74.1 lbs on 1/14/24 68.8 lbs on 2/1/24 (15.6% loss since 12/12/23 and 9% loss since 1/7/24) 69.8 lbs on 3/1/24 (continued on next page)

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

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F 0692 Level of Harm - Actual harm Residents Affected - Few	74.6 lbs on 4/1/24 and 70.1 lbs on 4/3/24 R21's Dietary/Nutrition Note dated 12/19/23 documents R21's BMI is 15.1, R21 is underweight related to inadequate oral intake and poor appetite. This note documents V20's recommendation of (nutritional supplement) Plus twice daily that is provided by R21's family, and give (comparable alternate nutritional supplement) 120 ml TID when unavailable. This note documents R21's family requested to be notified when supplement is running low. R21's Dietary/Nutrition Note dated 3/7/24 documents R21 accepts the comparable alternate nutritional supplement when the ordered supplement is unavailable. This note documents R21's meal intakes average 50-75%, but vary with occasional poor intakes and refusal of meals. This note documents the recommendation to continue with the same supplement amount and frequency noted on 12/19/23. There is no documentation in R21's medical record that R21's trending weight loss that began on 12/31/23 was reported to or evaluated by a physician. On 4/08/24 at 11:48 AM R21 was eating independently in the dining room. At 12:26 PM R21 ate approximately 75% of R21's meal. On 4/08/24 at 12:35 PM R21 stated R21's weight was down to 62 lbs at one time, and R21 didn't like that. R21 stated R21 has difficulty gaining weight and last week R21 weighed 70 lbs. R21 stated R21's appetite is pretty good and R21 has an upcoming doctor appointment to have R21's esophagus stretched, which usually helps with R21's eating. R21 stated the nurses give R21 a nutritional supplement that R21 likes. On 4/10/24 at 9:44 AM V7 Registered Nurse stated R21 gets (nutritional supplement) per orders and (comparable alternate nutritional supplement) can be given if the (nutritional supplement) is unavailable. V7 entered the medication room and showed the nutritional supplement bottles that are administered to R21. This supplement was not the Plus version of the (nutritional supplement) as ordered. On 4/10/24 at 1:31 PM V2 confirmed there is no documentation that R21's physician was notified of R21's weight loss. On 4/10/24 at 11:57 AM V20 RD stated there is a difference in the Original and Plus versions of (R21's ordered nutritional supplement). V20 stated (nutritional supplement) Plus is R21's preferred supplement that R21 was taking at home, and R21 should receive one bottle (237 ml) twice daily. V20 confirmed (nutritional supplement) Plus is ordered for R21 and provided by R21's family. V20 stated V20 was not aware that R21 was not receiving the ordered supplement and V20 will need to follow up on this right away as the Original and Plus supplements do not have equivalent nutritional content. V20 stated more of the Original will need to be given to equal the amount of Plus ordered. V20 confirmed the order should specify Plus, and not receiving the ordered supplement could have contributed to R21's weight loss.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to obtain orders for oxygen, failed to store, change, and label oxygen and nebulizer tubing in accordance with facility policy (R16, R19, R26) and failed to provide routine cleaning of a humidifier (R15). R15, R16, R19, R26 are four of five residents reviewed for respiratory care in the sample list of 31. Findings include: 1.) On 04/08/24 at 11:18 AM there was a humidifier on the table in R15's room. R15 stated R15 was unsure what the machine is used for. There is no documentation in R15's medical record that R15 uses a humidifier or routine cleaning/care of the humidifier. On 4/08/24 at 1:51 PM V13 Registered Nurse confirmed R15's humidifier and stated V13 is unsure how often it is used. V13 stated R15's family brought in the humidifier and provides care/maintenance for the machine. On 4/09/24 at 12:53 PM V2 Director of Nursing (DON) stated V2 provides a list of humidifiers to housekeeping staff to clean monthly. V2 stated V2 was unaware that R15 had a humidifier, which was brought in a couple months ago. V2 stated we do not obtain physician orders for humidifier use and the facility does not have a policy for humidifiers. 2.) On 04/08/24 at 10:44 AM and 1:40 PM R16's undated nebulizer mask and tubing were lying uncovered on top of R16's night stand. There were droplets of medication in the nebulizer chamber. At 10:44 AM R16 stated R16 had a respiratory infection that is improving, and R16 takes nebulizer treatments at least daily. R16's March and April 2024 Medication Administration Record documents R16's Albuterol nebulizer was administered six times, with the last administration on 4/7/24. R16's medical record does not document orders for routine changing of nebulizer equipment. 3.) On 04/08/24 at 11:24 AM R19 was lying in bed wearing oxygen at 2.5 liters per nasal cannula. The humidification bottle was dated 3/20/24 and the tubing was not labeled with date. R19's Physician Order dated 8/2/23 documents to change R19's oxygen tubing and humidification bottle weekly on Wednesdays. 4.) On 4/08/24 at 10:13 AM R26's oxygen tubing and nasal cannula was lying on the floor, and the tubing was dated 4/4/24. R26's oxygen concentrator did not contain a storage bag for R26's oxygen tubing. R26 stated R26 only wears oxygen at night. On 4/09/24 at 11:25 AM R26's oxygen tubing was labeled with a date of 4/4/24. R26's Order Summary dated 4/9/24 documents R26 admitted on [DATE], and does not include orders for oxygen administration or to routinely change oxygen tubing and humidification bottle. On 4/09/24 at 12:53 PM V2 DON stated oxygen and nebulizer tubing should be changed weekly and (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	labeled with a date, nebulizer tubing should be cleaned after use and stored in bag when not in use, and nasal cannulas should be stored in a bag when not in use. V2 stated yesterday V2 saw that R26 had thrown R26's nasal cannula on the floor. V2 stated we could provide a bag for R26's oxygen tubing, but R26 won't use it. V2 was asked if R26's oxygen tubing was changed and V2 stated V2 would have to look at the labeled date on the tubing. On 4/09/24 at 3:48 PM V2 stated there should be oxygen orders and orders for routine changing of oxygen and nebulizer tubing. The facility's Oxygen Therapy policy dated March 2024 documents the physician's order for oxygen administration should include the device and liter flow rate, oxygen tubing will be labeled with a date and changed weekly, and the tubing will be stored in a bag to prevent contact with the floor. The facility's Nebulizer Therapy policy dated 3/20/23 documents orders after nebulizer treatment administration, rinse the pieces used to administer the medication, allow to air dry, and once dry store the tubing covered. This policy documents to change the disposable nebulizer equipment weekly and label with a date.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record record review the facility failed to complete/accurately complete psychotropic medication assessments, quantify behaviors to justify the use of psychotropic medication, and attempt nonpharmacological interventions for behaviors for two residents (R14,R5) of five residents reviewed for psychotropic medications in a sample list of 31 residents. 1.) R5's Order Summary Report dated 4/10/24 documents R5 was admitted to the facility on [DATE] with diagnoses including Anxiety Disorder, Major Depressive Disorder, Delusional Disorder, and Paranoid Personality Disorder. This Order Summary documents orders for Buspirone HCL (hydrochloride) (antianxiety) 5 mg (milligrams) one table three times a day related to Anxiety Disorder and Major Depressive Disorder with a start date of 12/8/23, Escitalopram Oxalate (antidepressant) 10 mg every morning related to Anxiety Disorder and Major Depressive Disorder with a start date of 3/21/24 and Mirtazapine (antidepressant) 7.5 mg related to Major Depressive Disorder with a start date of 12/29/23. R5's Medical Record documents Psychoactive Medication Monitoring (assessments) with the first one dated 11/10/23 for Mirtazapine 15 mg. There is no behavior identified on this assessment for the Mirtazapine and the assessment does not list nonpharmacological interventions. R5's next Psychoactive Medication Monitoring assessment is dated 12/14/23 for Mirtazapine 15 mg at bedtime and Buspirone 5 mg three times a day. The behaviors are not quantified on this assessment and the assessment does not document nonpharmacological interventions. R5's last Psychoactive Medication Monitoring assessment is dated 3/15/24 for Buspar 5 mg three times a day and Mirtazapine 7.5 mg at bedtime and Escitalopram 5 mg daily. The behaviors are not quantified and there are no nonpharmacological interventions documented on the assessment. R5's Medical Record does not document a psychotropic medication assessment for the increased dose of Escitalopram 10 mg every morning started on 3/21/24. On 4/10/24 at 3:00 PM, V3 Assistant Director of Nursing confirmed the behaviors are not quantified on the psychotropic medication assessments and confirmed there is no assessment for R5's increase of Escitalopram. The facility's Psychotropic Drug Policy and Procedure with a revised date of March, 2024 documents, It is the policy of (the facility) that psychotropic drugs are not to be used if avoidable and never as a chemical restraint. They are to be used with a physician's order, written permission of the resident or legal representative, and an appropriate diagnosed indication need. Behavior Monitoring will document specific behavior that indicates the need for administration of the medication. There will be an assessment on admission and quarterly concerning the resident's response and progress while receiving the medication. 2.) R14's current diagnosis sheet includes the following Diagnoses: Anxiety, Depression, and Dementia. R14's Medication Administration Sheet (MAR) for 4/1/24 through 4/31/24 includes the following physician's orders for psychotropic medications: Seroquel (antipsychotic) 25 milligrams twice daily, Ativan (antianxiety) 0.5 milligrams every hour as needed, Zoloft (antidepressant) 50 milligrams daily. The Psychoactive Medication assessment dated [DATE] documents R14 has behaviors of anxiety and (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	constantly yelling out. There is no documentation in R14's medical record to indicate nonpharmacological interventions have been attempted for R14. There is no documentation of interventions attempted to address R14's behaviors or R14's response to interventions. On 4/10/24 at 2:00PM V10, Care Plan Coordinator stated I do not have documentation of nonpharmacological interventions or response to interventions.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to label opened prepared foods with the date and time in the refrigerator. This failure has the potential to affect all 90 residents who reside in the facility. Findings Include: The facility's midnight census as of 4/8/24 is documented as 90. On 4/08/24 at 9:00AM, [NAME] slaw, whipped topping, and sour cream were observed in the refrigerator not labeled with a date or the time in which they were opened. At this same time, (V21), Dietary Manager stated I can't say how long these items have been in the refrigerator since they are not labeled. I will discard them. Food items should definitely be labeled with the date and time opened before being placed in the refrigerator.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 3.) R149's Order summary printed 4/10/24 at 3:38PM includes the following Physician's order: Right buttock pressure area: Cleanse with Normal Saline, apply skin prep around wound bed, apply hydrocolloid every 3 days and PRN (as needed) every night shift. On 4/8/24 at 9:00AM, R149 was observed sitting in R149's room. R149 had a urinary catheter in place with the drainage bag on her chair. There was no sign on R149's door indicating enhanced barrier precautions and there was no PPE (Personal Protective Equipment) available upon entering R149's room. 4.) R150's Order Summary printed 4/10/24 at 4:03PM includes a physician's order originating 3/27/24 for Right buttock open area: Cleanse with Normal Saline, apply hydrocolloid every evening shift every 3 day(s). This order summary also documents a physician's order originating 4/9/24 for Left buttock open area: Cleanse with NS (normal saline), apply skin prep around wound bed, apply hydrocolloid every evening shift every 3 day(s). On 4/10/24 at 11:15AM, R150's treatment was observed being applied by V6, Registered Nurse (RN) R150 had a Stage II pressure ulcer on right and left buttocks. V6 did not wear a gown during R150's wound treatment. There was no sign on R150's door indicating enhanced barrier precautions and there was no PPE available upon entering R150's room. 5.) On 4/10/24 at 10:50AM, V6 was observed applying a wound treatment to the open pressure ulcers on R33's right and left buttocks. V6 did not wear a gown while completing the treatment to R33's open wound. On 4/10/24 at 11:00 AM, V22 Certified Nurse's Aide (CNA) and V23 Certified Nurse's Aide (CNA) proceeded to perform catheter care for R33. Neither V22 nor V23 wore a gown. There was no sign on R33's door indicating enhanced barrier precautions and there was no PPE available upon entering R33's room. V22 stated (R33) isn't on any isolation so we just need to wear gloves. Based on observation, interview, and record review the facility failed to implement enhanced barrier precautions as recommended by the Centers for Disease Control and Prevention. This failure affects five (R31, R97, R149, R150, R33) of five residents reviewed for enhanced barrier precautions in the sample list of 31. Findings include: 1.) On 4/09/24 at 1:26 PM V11 and V15 Certified Nursing Assistants entered R31's room and provided (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	urinary catheter care. V11 and V15 did not wear gowns during R31's care and there was no signage posted on R31's door to indicate enahanced barrier precautions (EBP) use when providing R31's cares. R31's Care Plan dated 2/19/24 documents antibiotics were ordered to treat a Urinary Tract Infection. This Care Plan documents R31 has an indwelling urinary catheter due to urinary retention and includes interventions for contact isolation due to colonization of MRSA (Methicillin Resistant Staphylococcus Aureus (multidrug resistant organism). On 4/10/24 at 2:30 PM V2 Director of Nursing/Infection Preventionist stated the facility does not have a policy for EBP yet. V2 provided a copy of EBP signage and stated the policy will be based on the EBP signage. The EBP signage provided by V2, documents to perform hand hygiene upon entering and leaving the room, wear gloves and gown for the following high contact resident care activities - dressing, bathing/showering, transferring, changing linens, providing hygiene, changing incontinence briefs, assisting with toileting, device care/use (central lines, urinary catheters, feeding tubes, tracheostomy), and wound care (any skin opening that requires a dressing). 2.) R97's Care Plan dated 4/5/24 documents R97 has an indwelling urinary catheter. On 4/8/24 at 10:24 AM there was no signage posted on R97's doorway to indicate EBP use when providing R97's cares. On 4/9/24 at 1:14 PM V11 and V15 provided R97's urinary catheter care. V11 and V15 did not wear gowns during R97's care. The CDC Consideration for Use of Enhanced Barrier Precautions in Skilled Nursing Facilities dated June 2021 documents a recommendation for EBP use (gloves and gown) when providing high contact cares for residents with indwelling devices or wounds to prevent the spread of multidrug resistant organisms.

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	04/10/2024

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to maintain documentation of immunization status, and offer/administer Pneumococcal and Influenza (Flu) Vaccines for three (R31,R21,R26) of five residents reviewed for immunizations in the sample list of 31. Findings include: The facility's Influenza and Pneumococcal Immunization policy dated April 2024 documents the facility will offer residents pneumonia vaccinations and Influenza vaccinations based on the Centers for Disease Control and Prevention (CDC) Guidelines, and the Nursing Department is responsible for ensuring residents receive the pneumonia and Influenza vaccine and documentation is completed. This policy documents that residents will be screened annually for Influenza vaccination during the months of October 1st (or as soon as its available for the season) - March 31st unless immunization is medically contraindicated or the resident has already been immunized during this time period. On admission all residents will be offered the appropriate Pneumococcal vaccine if they have not been vaccinated, unless contraindicated. The CDC Pneumococcal Vaccine Timing for Adults dated 3/15/23 documents to make sure Pneumococcal vaccinations are up to date and recommends for people over age [AGE] who have only received Pneumococcal polysaccharide vaccine (PPSV23), to have Pneumococcal Conjugate (PCV15) or Pneumoccocal Conjugate (PCV20) at least one year after the most recent Pneumococcal vaccination. The CDC Influenza Vaccine Timing for Adults dated 3/21/24 documents to ensure all adults age [AGE] or older are up to date and offered a Influenza Vaccine annually between the months of September- March. R31's Electronic Medical Record reviewed 4/10/24 documents R31 admitted to facility on 3/18/24, that R31 received Flu Vaccine on 9/26/2022, the Pneumovax (no specified type) on 12/14/1995, and PCV13 on 8/6/15. R31's medical record documents R31 is over age [AGE]. R31's medical record does not document that Flu or Pneumonia vaccines were offered. R21's Electronic Medical Record reviewed 4/10/24 documents R21 is over age [AGE]. R21 has no record of immunizations in R21's medical record or documentation that Influenza and Pneumonia vaccines were offered after admitting to the facility on 2/5/24. R26's Electronic Medical Record reviewed 4/10/24 documents R26 was admitted to the facility on [DATE], that R26 is over age [AGE], and that R26 received PPSV23 on 1/1/2000. There is no documentation that the Pneumococcal vaccine was offered to R26 after R26 was admitted to the facility. On 4/10/24 at 11:00 AM, V3 Assistant Director of Nursing was asked what the process is in regards to offering vaccinations to residents. V3 stated that Flu, Pneumonia, and COVID vaccines are offered on admission. V3 stated that they also review hospital records for immunizations. V3 was asked about documenting consent/declination of vaccinations. V3 stated that they have a form, but the form was missed for R31, R21 and R26. V3 was unable to provide documentation showing Flu and Pneumococcal vaccines were offered on admission to R31, R21, and R26. V3 confirmed R21's medical record did not document R21's Flu and Pneumonia vaccination status.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145400	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2024
NAME OF PROVIDER OR SUPPLIER Westminster Village		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to offer and administer COVID-19 vaccination boosters to two (R31, R21) of five residents reviewed for COVID-19 vaccinations in a sample list of 31 residents. Findings include: 1. R31's undated face sheet includes diagnoses of History of COVID-19, Hypertension, Metabolic Encephalopathy, Hypo-Osmolality and Hyponatremia. R31's Electronic Medical Record reviewed 4/10/24 documents R31 received a COVID-19 Vaccine on 5/3/2022, and R31 was admitted to the facility on [DATE]. R31's medical record does not document education was provided to R31 regarding COVID-19 vaccination, nor does it document a COVID-19 booster was offered or administered. 2. R21's undated face sheet includes diagnoses of Pneumonia, Anemia and Cerebral Infarction. R21's Electronic Medical Record reviewed 4/10/24 documents R21 was admitted to the facility on [DATE]. This record does not document that COVID-19 vaccinations were offered or given to R21, or of vaccine history/status. On 4/10/24 at 11:00 AM V3 Assistant Director of Nursing was asked what the process is in regards to offering vaccinations to residents. V3 stated that Flu, Pneumonia and COVID vaccines are offered on admission. V3 stated that they also review hospital records for immunizations. V3 was asked about documenting consent/declination of vaccinations. V3 stated that they have a form, but the form was missed on R31 and R21. V3 was unable to provide documentation showing COVID-19 Vaccinations were offered on admission to R31 and R21. V3 confirmed R21's medical record did not document R21's COVID-19 vaccination status. The facility policy titled Offering COVID-19 Immunization revised January 2024 documents the facility will make available the latest Sars-COVID-19 immunizations for all residents and all residents will be offered upon admission unless immunization is medically contraindicated or the resident has already been immunized during this time period. If the vaccine is not available during this time frame, every reasonable attempt to obtain the vaccine will be made. This policy documents there will be documented consent or refusal of the COVID-19 vaccine.