STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146168	A. Building B. Wing	07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ahva Care of Winfield	28 West 141 Liberty Street Winfield, IL 60190

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect residents' right to be free from physical abuse by another resident. This applies to 2 of 3 residents (R1, R2) reviewed for resident-to-resident abuse in the sample of 3. The findings include: 1. On June 30, 2025, at 1:10 PM, R1 was lying in bed in her room. R1 refused to discuss the altercation between R1 and R2 that occurred on June 7, 2025. The EMR (Electronic Medical Record) shows R1 was admitted to the facility on [DATE]. R1 has multiple diagnoses including, polyneuropathy, delusional disorders, hallucinations, schizoaffective disorder, bipolar disorder, asthma, heart failure, major depressive disorder, cognitive communication deficit, paranoid personality disorder, and psychosis. R1's MDS (Minimum Data Set) dated June 23, 2025, shows R1 is cognitively intact, requires partial/moderate assistance with eating and oral hygiene, and substantial/maximal assistance with all other ADLs (Activities of Daily Living). R1 is frequently incontinent of urine, and always continent of stool. On June 7, 2025, at 11:45 AM, V3 (Registered Nurse/RN) documented, Around 11:15 AM received report from PRSC (Psychiatric Rehabilitation Services Coordinator) that this resident (R1) made physical contact to [R2's] right upper arm after exchanging words with each other and [R2] made physical contact on this resident's abdomen. Per report, staff intervened and separated these two residents. Incident reported to abuse coordinator right away by PRSC on duty. Body check done, no redness or any markings on the abdomen denies any pain or discomfort.Resident already calmed down when writer went to speak to her. On June 7, 2025, at 2:19 PM, V4 (Social Services/SS) documented, [R1] exchanged words with another resident, and made contact with her arm. Other resident made contact back. The two were separated, and responsible parties alerted. Report was sent. R1's behavior monitoring dated June 7, 2025, at 1:59 PM shows R1 was observed hitting others, physically aggressive towards others, and expressed frustration/anger at others. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Preliminary Incident Investigation Report dated June 7, 2025, shows: On 06/07/25, [R1] came into physical contact with [R2's] right upper arm after they exchanged words with each other. Both report that [R1] made contact with [R2] first and then [R2] made contact with [R1's] stomach. Staff immediately intervened and separated the two.An investigation has been started and a final report will be sent to (state surveying agency) upon completion. The facility's Final Incident Investigation Report dated June 12, 2025, shows: Final: [R1] was provided 1:1 education regarding anger management. [R1] reports that she does not remember the incident. [V9] (POA-Power of Attorney for R1) reported that [R1] has had more periods of forgetfulness and has a history of poor anger management due to her verbally abusive father. Staff will encourage [R1] to engage in more structured programs. [R2] is assigned to Anger Management and expressed understanding on not hitting another resident. [R2] felt that she should defend herself. Staff will continue to monitor. 2. On June 30, 2025, at 11:39 AM, R2 was lying in bed in room. R2 said she had an altercation with R1 on June 7, 2025, near the facility's elevator on the first floor. R2 continued to say the two residents started hitting each other. R2 said, [R1] hit me first and I hit her back. She kicked me too. The EMR shows R2 was admitted to the facility on [DATE], with multiple diagnoses including, bipolar disorder, suicidal ideations, absence epileptic syndrome, chronic atrial fibrillation, lack of coordination, weakness, cognitive communication deficit, Type 2 diabetes, heart disease, depression, psychosis, and schizoaffective disorder. R2's MDS dated [DATE], shows R2 is cognitively intact and requires partial/moderate assistance with all ADLs. R2 is occasionally incontinent of urine, and always continent of stool. On June 7, 2025, at 11:45 AM, V3 (RN) documented, Around 11:15 AM received report from PRSC that this resident made physical contact to [R1's] abdomen after exchanging words with each other and [R1] made physical contact on this resident's right upper arm. Per report staff intervened and separated these two residents. Incident reported to abuse coordinator right away by PRSC on duty. Body check done, no redness or any markings on the right upper arm denies any pain or discomfort.Resident already calmed down when writer went to speak to her. On June 7, 2025, at 2:24 PM, V4 (SS) documented, [R2] exchanged words with another resident and contact was made to her arm. This resident made contact back to the other resident, and they were separated. Appropriate guardian and staff were made aware of incident and report was sent. R2's behavior monitoring dated June 7, 2025, at 1:59 PM shows R2 was observed hitting others, physically aggressive towards others, and expressed frustration/anger at others. On June 30, 2025, at 11:41 AM, V5 (Certified Nursing Assistant) said, I was there when [R1] and [R2] got in a fight. They were both in their wheelchairs near the elevator. I had to separate them. On June 30, 2025, at 2:04 PM, V4 (SS) said, If I remember, [R2] came up to tell me that she defended herself, that [R1] hit her and then said she hit the other resident. [R1] said she hit [R2]. She said she was very upset. [R2] was upset about the toilet, and that [R1] never flushes the toilet. That is why [R1] hit her. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On June 30, 2025, at 2:26 PM, V1 (Administrator) said, They said they came in contact with each other. [R1] hit [R2], and [R2] hit back. It was over the toilet not being flushed. It was a heated argument that became physical. The facts were very clear. Staff were present. On June 30, 2025, at 2:31 PM, V3 (RN) said, I was not present. I did not see the altercation. It happened on the first floor, and I was on the second floor. [R1] and [R2] said they hit each other. Both residents have a temper. The facility's policy entitled, Policy and Guidelines on the Prevention of Abuse and Neglect, dated 02/03/23 shows: Policy: The facility must provide a safe resident environment and protect residents from abuse. The residents of the facility have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this policy. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Procedure/Guidance: .6. Physical Abuse: a. Physical abuse includes but is not limited to, hitting, slapping, punching, biting, and kicking.