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No. 0938-0391

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	02/21/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45906 Based on observation, interview, and record review, the facility failed to maintain the call light within access for one resident. This applies to 1 resident (R130) reviewed for accommodation of needs in a sample of 30. Findings include: On 2/18/25 at 1:13 PM, R130 was observed sitting on the side of his bed with his pants half falling off his hips and his brief sticking out of his pants. R130s call button was noted to be draped over the side of his wheelchair and out of R130's reach. R130 stated, how am I supposed to get this without falling down. R130 added that the nurse had been in the room to give him medications and did not give him the call button. R130 stated that 75% of the time the staff does not give him the call button. R130 also stated that he fell on [DATE] because his button was not in reach and he was reaching for it. R130's MDS (Minimum Data Set) dated 1/13/25 shows his cognition is intact and R130 needs substantial/maximal assistance for personal hygiene. R130's care plan dated 1/7/2025 documents that R130 is at risk for falls and interventions include keeping the call light within reach and encouraging the resident to use the call light for assistance as needed. On 2/18/2025, V2 (Director of Nursing) stated that when staff leave a room the call light should be placed within the resident's reach. V2 added that if the resident cannot reach their call light and they are not able to call for help, they could try to transfer or toilet themselves and risk falling.

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48944 Based on observation, interview, and record review, the facility failed to maintain accurate advanced directives in the residents' medical records. This applies to 3 out of 4 (R27, R76, and R47) residents reviewed for advance directives in a sample of 30. The findings include: 1. On [DATE] at 11:15 AM, V12 (Licensed Practical Nurse/LPN) said the facility maintained a binder with Do Not Resuscitate (DNR) advance directive forms on top of the unit's emergency crash cart. V12 also said all residents required a code status order in their EMRs (Electronic Medical Records) to reflect their selected advanced directives. V12 was asked to review R27, R47, and R76's EMRs code status. V12 said R27 and R47's EMRs showed full code orders (to be resuscitated) and R76's EMR did not show a code status order. V12 then reviewed the DNR binder which showed R27, R47, and R76 had POLST (Practitioner Order for Life-Sustaining Treatment) forms indicating they had selected DNR (not to be resuscitated). V12 said the DNR binder information had to match with the resident's EMR to ensure that the staff knew how to respond to a resident's medical emergency based on their life-sustaining wishes. On [DATE] at 10:50 AM, V11 (Social Worker/SW) said she was responsible for assisting residents with their POLST forms. V11 said she then provided the nursing team with a copy of the forms to ensure correct code status orders were entered into the residents' EMRs. V11 confirmed R27, R47, and R76's POLST forms indicating their DNR wishes were accurate. R27's Care Plan Report showed an advance directive focus for DNR initiated on [DATE]. The care plan's interventions included document the DNR status on the Physician's Order Sheet, Inform caregivers of the DNR status, and Place a code/mark on the chart so it clearly identifies the DNR status. R27's POLST (Practitioner Order for Life-Sustaining Treatment) form dated [DATE] showed R27 selected NO CPR; Do Not Attempt Resuscitation (DNAR). R27's Order Summary Report dated [DATE], showed an active code status order of Full Code CPR ATTEMPT CARDIOPULMONARY RESUSCITATION dated [DATE]. 2. R47's Care Plan Report showed an advance directive focus for DNR initiated on [DATE]. The care plan's interventions included document the DNR status on the Physician's Order Sheet and Place a code/mark on the chart so it clearly identifies the DNR status. R47's POLST form dated [DATE] showed R47 selected NO CPR; Do Not Attempt Resuscitation (DNAR). R47's Order Summary Report dated [DATE], showed an active code status order of Full Code CPR ATTEMPT CARDIOPULMONARY RESUSCITATION dated [DATE]. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm 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** 40054 Based on the interview and record review, the facility failed to notify the POA (Power of Attorney), physician, and hospice provider in a timely manner before transferring R131 to the hospital for evaluation after a fall incident. This applies to 1 of 2 hospice residents (R131) who were reviewed for significant change in condition and hospitalization in a sample of 30. Findings include: On 02/18/2025 at 10:31 AM with V15 (Registered Nurse/RN), R131 was observed with a skin tear on the left elbow. V15 said R131 had a fall on 02/17/2025 and went to the hospital for evaluation. V15 said she was not involved in the incident and was not aware of the details. On 02/18/25 at 01:46 PM, V17(RN) said R131 had an unwitnessed fall, and the facility called 911 and transferred R131 to the hospital. V17 stated she informed later the hospice provider and the physician and forgot to notify R131's POA (Power of Attorney) R131's Electronic Medical Records (EMR) showed R131 was admitted to hospice care on 01/30/2025 due to cerebra vascular disease for comfort care only and diagnoses including cerebral infarction, protein-calorie malnutrition, enterocolitis due to clostridium difficile, chronic obstructive pulmonary disease, and altered mental status. R131's admission Minimum Data Set (MDS) dated [DATE] showed R131 was not interviewable and cognitively severely impaired and dependent on one to two staff assistance for activities of daily care. Nursing progress notes dated 02/17/2025 showed R131 had an unwitnessed fall at 12:25 PM and was admitted to the hospital for dehydration and abnormal sodium level. The nursing progress notes from the next shift showed that a nurse informed R131's POA regarding R131's admission to the hospital around 7:08 PM. The progress notes further indicated that the POA stated she was not aware that the patient got sent out to the hospital and did not want R131 to be admitted , and the facility brought R131 back to the facility. On 02/19/2025 at 12:12 PM, V18(Registered Nurse-Hospice) said that the hospice staff received the call regarding his change in condition around 2:45 PM. V18 said the practice is the facility notifies the fall as soon as it is observed, and the hospice sends a nurse to evaluate the residents and notify the family of any decision to make. V18 said R131 had an order from the hospice physician about not hospitalizing. V18 stated that the facility called her when R131 was already out to the hospital via 911 for evaluation, and she advised the facility to notify the family. On 02/19/25, at 10:09 AM, V2(Director of Nursing) said the appropriate parties are notified as soon as any change in resident conditions or hospital transfer occurs. The facility's policy, Care of Resident with a Change in Condition, revised dated 03/2020, states that after the resident is assessed and noted to have a change in conditions, the resident's provider should be notified for further medical intervention, and the resident's responsible party should be notified about the change of conditions.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39182 Based on observation, interview, and record review, the facility failed to ensure residents were provided with a clean and comfortable room. This applies to 4 out of 4 residents (R7, R117, R127, R130) reviewed for environment from a total sample of 30. Findings include: 1. On 2/18/25 at 11:35AM R127 was in bed covered with two comforters. R127's MDS (Minimum Data Set) assessment of 12/13/2024 defines R127 as cognitively intact. R127 stated her room was always cold. R127's face-sheet shows R127 was an 80 y/o female admitted to the facility on [DATE] with diagnoses to include Schizoaffective Disorder, Hypertension, Chronic Obstructive Pulmonary Disease and Protein-Calorie Malnutrition. 2. On 2/18/25 at 11:38AAM R117 was observed in bed covered with a comforter. R117 stated her room was very cold, and it was always cold. R117 stated that she is comfortable under her blanket. R117's face-sheet showed R117 is admitted to the facility on [DATE] with diagnoses to include Schizoaffective Disorder, Depression, Unspecified Psychosis and Hypertension. R117's MDS dated [DATE] showed she was cognitively intact. 3. On 2/18/24 at 11:42 AM, observed R7 in a wheelchair, going out of her room. R7 was wearing a sweater, a hat, and a scarf around her neck. R7 stated she is wearing her winter attire because her room was very cold. R7's face-sheet showed, R7 was a 66 y/o female admitted to facility on 10/07/1997 with diagnoses to include Schizoaffective Disorder, Paranoid Schizophrenia, Hypertension, Diabetes Mellitus and Thrombocytopenia. R7's MDS dated [DATE] showed she was cognitively intact. On 2/18/25 at 12:15 PM V19 (Maintenance Director) stated, resident's room temperature must be 69-81F (degrees Fahrenheit). V19 (Maintenance Director) stated, they usually keep it above 71F as most residents are comfortable at 71F or above. V19 (Maintenance Director) checked the room temperature, and it was 63F. He re-calibrated his thermometer and the thermometer still showed 63F. On 2/20/25 at 2:00 PM, V1 (Administrator) stated, the thermostat in R7's room was broken. Policy on 'Homelike Environment' revised in March 2020 showed, ' 2. Characteristics of a personalized, homelike setting g. comfortable room and water temperatures. 5. Room Temperatures: maintain comfortable and room temperatures levels near a range of 71 to 81F. 4. On 2/18/25 at 1:13 PM, R130 was observed sitting on the side of his bed with his pants half falling off his hips and his brief sticking out of his pants. R130 had a foul odor coming from his side of the room. R130's urinal was sitting on his meal tray in front of him with a noted dark brown substance/what appeared to be stool around the rim. R130 said his urinal has been dirty around the rim for as long as he could remember. R130's MDS (Minimum Data Set) dated 1/13/25 shows his cognition is intact.

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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** 40054 Based on the interview and record review, the facility failed to follow the hospice physician's order for hospitalization . This applies to 1 of 2 hospice resident (R131) who was reviewed for hospitalization in a sample of 30. Findings include: Hospice provider order dated 01/30/2025 for R131 indicated do not hospitalize, call with change in condition, and comfort care only. On 02/18/25 at 01:46 PM, V17(Registered Nurse) said R131 had an unwitnessed fall, and the facility called 911 and transferred R131 to the hospital. V17 stated she informed the R131's physician later. V17 said she did not realize that R131 was not to be hospitalized . 02/19/25 V2 (Director of Nursing) said nurses should follow physician orders. R131's Electronic Medical Records (EMR) showed R131 was admitted to hospice care on 01/30/2025 due to cerebra vascular disease for comfort care only and diagnoses including cerebral infarction, protein-calorie malnutrition, enterocolitis due to clostridium difficile, chronic obstructive pulmonary disease, and altered mental status. R131's admission Minimum Data Set (MDS) dated [DATE] showed R131 was not interviewable and cognitively severely impaired and dependent on one to two staff assistance for activities of daily care. On 02/19/2025 at 12:12PM, V18 (Registered Nurse-Hospice) said R131 had an order from the hospice physician about not hospitalizing. V18 said when the facility called her when R131 was already out to the hospital via 911 for evaluation. The facility's policy, Physician Order-Medication and Treatment with a revised date of 03/2020, states in part physician order should be carried out as ordered. The policy Care of Resident with a Change in Condition, with a revised date 03/2020 states in part after the resident was assessed and noted to have a change in conditions, the resident's provider should be notified for further medical intervention.

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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** 48944 Based on observation, interview, and record review, the facility failed to safely transfer residents who required the use of a mechanical lift. This applies to 3 out of 3 (R32, R75, R104) residents reviewed for transfers in a sample of 30. The findings include: 1. R104's EMR (Electronic Medical Record) showed his diagnoses including lack of coordination, abnormalities of gait and mobility, muscle weakness in his right lower leg, gout, epilepsy, and dementia. R104's EMR said he required the use of a mechanical sit-to-stand machine lift for all transfers. R104's MDS (Minimum Data Set) dated 1/30/2025 said he was dependent on facility staff for transfers. On 2/19/2025 at 9:10 AM, V7 (Certified Nursing Assistant/CNA) and V8 (CNA) said they were going to transfer R104 from his wheelchair to the toilet. V7 said R104 required the use of the sit-to-stand mechanical lift for transfers. V7 said R104's right lower leg was weak and required additional support. V7 and V8 then placed R104's feet on the machine's footplate. The machine's knee pad had straps with attached belt bulk pieces on each side. V7 said they did not have the knee belt piece attachment to secure to the machine. V7 said they were told that the additional safety knee device was not required. They then proceeded to place and secure a red-colored belt sling around R104's torso area. V7 pulled to adjust the belt strap fully but it was not securely fastened around R104's torso. They then hooked the sling's loops to the machine and transferred R104 to the toilet. After assisting R104 with his toileting needs they then transferred him back to his wheelchair. When R104 was lifted the belt remained loose not fastened securely. R104 started slightly lowering further in his squatting position while being transferred into his wheelchair. 2. R32's EMR showed her diagnoses included loss of muscle control related to [NAME]-Sachs disease, scoliosis of the lumbar region, lack of coordination, general muscle weakness, Charcot's joint to the right shoulder, unsteadiness on feet, polyosteoarthritis, and neuropathy. R32's EMR said she required the use of a mechanical sit-to-stand machine lift for all transfers. R32's MDS dated [DATE] said she was dependent on facility staff for transfers. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/19/2025 at 1:05 PM, V7 and V8 (CNAs) said they were going to transfer R32 from her wheelchair to the toilet with the sit-to-stand mechanical lift. R32 had a black sling on her right arm. R32 said she used the sling for additional support because her arm was weak. They placed R32's feet on the machine's footplate. The machine's knee pad had slots on each side for attaching a knee belt but did not have belt straps attached. V7 placed and secured the same prior used (with R104's AM transfer) red-colored belt sling around R32's torso area. V7 pulled on the belt strap fully to adjust it but it was not too big and not fastened securely around R32's torso. They proceeded with R32's transfer when another staff member handed V7 another belt sling of a smaller size. After assisting R32 with her toileting needs they then transferred her back to her wheelchair. R32's belt sling remained loose despite V7 again attempting to fully pull on the belt to fasten it. V7 said the belt sling used for R32 was too loose. After the transfer, R32's belt sling was inspected with V7, and it did not have the manufacturer's tag attached indicating the size and said she believed that was a large size. V7 said that they determined the belt sling size based on the residents' posterior torso width. V7 said they had other belt sizes available including small and medium and were not specific to the machine's manufacturing product. V7 said both R32 and R104 required the use of a medium size belt slings based on their torso size. 3. R75's EMR showed her diagnoses included left-side hemiplegia, hand contractures, dystonia (involuntary muscle contractures), abnormalities of gait and mobility, and muscle weakness. R75's EMR said she required the use of a mechanical sit-to-stand machine lift for all transfers. R75's MDS dated [DATE] said she was dependent on facility staff for transfers. On 2/19/2025 at 9:35 AM, V9 (Restorative Aide) and V10 (CNA) said they were going to transfer R75 from her wheelchair to the toilet with the sit-to-stand mechanical lift. V9 said the machine was a rental without a knee belt attached. They placed R75's feet on the footplate and a belt sling around her torso. They then hooked the sling's loops to the machine and instructed R75 to hold on to the machine. R75's left hand was contracted and was unable to grip onto the machine's handlebar, she placed her hand over it. V9 pulled on the belt strap fully to adjust it but it was still too loose and not fastened securely around R75's torso. They proceed to transfer R75 to the toilet. On 2/20/2025 at 9:50 AM, V9 said the facility had different belt sling sizes and R75's size was probably medium. V9 said belt sizes were based on the resident's chest size, and when the belt is fastened it should not be too loose nor too tight. V9 was asked to inspect the belt sling used on R75 (during her AM transfer observation on 2/19/2025). V9 was unable to determine the size of the belt sling because it did not have the manufacturer's tag attached indicating the size. On 2/19/2025 at 1:20 PM, V2 (Director of Nursing) was asked to inspect R104's used sit-to-stand mechanical lift machine. V2 said that based on the knee pad's attached belt straps the machine most likely required the use of the knee belt but was unsure if the machine was purchased with it. Then V2 was asked to inspect the machines used for R32 and R75 transfers, V2 said she was not sure if those machines required the use of the belt knee belt attachment device. V2 was also asked to inspect the belt slings used for R104, R32, and R75. She was unable to determine the size of the slings. V2 said she was unsure how the staff determined or knew which size belt sling to use for the residents. V2 said the facility used universal belt slings that could be used for all the facility's lift machines, including their rental machine. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/19/25 at 3:20 PM, V2 said she interviewed the staff and confirmed that they were instructed by V13 (Risk Manager Consultant) that the use of knee belts was not needed because they did not assist in preventing falls. V2 said she contacted V13 for additional guidance regarding the use of the knee belts. V2 said they reviewed the machine's manufacturing instructions, and determined their use was not required only recommended, and if decided to be used they would need to be ordered. V2 also said she expected the staff to use their best judgment when determining which size of belt slings to use. On 2/20/2025 at 10:15 AM, V13 (Risk Manager Consultant) said she was employed by an outside insurance company that provided employee safety education including on how to safely transfer residents. V13 said her company did not maintain the facility's transfer equipment. V13 said she was not familiar with the facility's mechanical lift machines. V13 said she provided the facility's staff with directions on how to use lift transfer machines and instructed them that knee belts were optional but not required. V13 said knee strap belts could be used for residents who require extra security with transfers for example those who have lower leg weakness. V13 said the facility had to individually assess residents who may require the additional support of knee belts and update their care plans. V13 also said that she believed belt sling sizes were determined based on weight and the belt's manufacturing tag should be assessed to determine the belt's size. V13 said the belt should be fastened like a gait belt (a standard transfer belt), it should be snugged but not too tight. V13 said it was important that the belt be secured appropriately around the resident to prevent accidents. The (name of the sit to stand machine) manufacturing document undated was provided by the facility. The instructions said, ALWAYS check the slings weight capacity is suitable for the patient and Fitting Stand Assist Sling .2. Cross the adjustable chest belt over and fasten it securely using the buckle. The document also said there was an option to add the knee support straps and included instructions for the use of a fitting knee belt. The facility's document letter from (name of the sit to stand machine) dated 2/20/2025 said the knee strap for the lift was an optional accessory. The document further said, This accessory is available for situations where nursing or caregiver judgment determines that additional knee support is needed to enhance patient stability against the knee pad. The facility's document titled How to Use a Stand Assist Lifter Safely undated provided instructions on how to make transfers safer and more comfortable. The document said Step 2: Attach the appropriate sling .You should select the correct size sling for the person who will be donning the sling. Check the product guide, where you can find information on what size you will need .Step 6: Adjust any optional feature .Optional leg bands are also available for increased stability and lower leg support during transfers . The facility's policy titled Transferring a Resident from one location to another dated 03/2020, said Policy Statement Residents in the facility will be transferred safely from one location to another using the proper transfer technique. Policy Interpretation and Implementation .2. Mechanical lift or sit-to-stand lift .14. Apply positioning and/or physical devices as indicated .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48944 Based on observation, interview, and record review, the facility failed to dispose of controlled medications accordingly and have as-needed medication available for administration upon resident request. This applies to 5 out of 5 (R103, R65, R26, R10, and R73) residents reviewed for medication storage and pharmacy services in a sample of 30. The findings include: 1. On 2/18/2025 at 12:55 PM, the medication storage task was done with V15 (Registered Nurse/RN) on the second floor. R10's Ativan 0.5 mg (milligrams) medication bottle containing 20 tablets was in the medication room's refrigerator. R10's Ativan Controlled Substances Proof of Use record sheet was wrapped around the medication (not in the unit's narcotic control counting log binder). V15 said the medication did not require refrigeration and was unsure why it was stored in the refrigerator. V15 also said the record sheet had to be in the narcotic control binder to ensure the medication was being accounted for. V15 then gave R10's medication and record sheet to V3 (Licensed Practical Nurse/LPN). V3 said R10's Ativan tablets were discontinued, and he was now receiving it in liquid form. R10's Order Summary Report dated 2/19/2025 did not show an order for Ativan tablets. 2. On 2/18/2025 at 1:05 PM, the second floor's unit medication cart was checked with V15 (RN). R26's Lorazepam 1 mg medication punch card was observed with the #8 pill slot punched opened, with tape over it with a pill inside. R26's Order Review Report dated 2/19/2025 showed an order for Ativan Oral Tablet 1 MG (Lorazepam) Give 1 mg by mouth every 6 hours as needed for anxiety. 3. On 2/18/2025 at 1:25 PM, the first floor's unit medication cart was checked with V4 (RN). R103's Lorazepam 0.5 mg medication punch card with 28 tablets had R103's Controlled Drug Receipt/Record/Disposition form wrapped around the card (not in the unit's narcotic control counting log binder). R103's Order Review Report dated 2/19/2025 did not show an order for Lorazepam. 4. On 2/18/2025 at 1:25 PM, V4 remained present for R65's medication observation. R65's Clonazepam 1 mg medication punch card with 27 tablets had R65's Controlled Drug Receipt/Record/Disposition form wrapped around the card (not in the unit's narcotic control counting log binder). V4 said R103 and R65 were discharged from the facility, and their controlled medications should have been removed and given to the Director of Nursing/DON to ensure proper destruction. R65's Order Review Report dated 2/19/2025 showed an order for clonazepam Oral Tablet 1 MG (Clonazepam) Give 1 tablet via G-Tube one time a day related to BIPOLAR DISORDER. On 2/19/2025 at 1:30 PM, V2 (DON) said all controlled medications should be accounted for and disposed of when discontinued to prevent discrepancies and variances. V2 also said controlled medications should never be placed back into the punch cards once removed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146168	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/21/2025
NAME OF PROVIDER OR SUPPLIER Ahva Care of Winfield		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's policy titled Controlled Substances dated 11/2015, said The facility will dispose of or destroy any discontinued controlled substances in a safe and controlled manner in accordance with the regulation set forth by the Drug Enforcement Agency (DEA) .Destroying Controlled Drugs 9. When a resident refuses a non-unit dose medication (or it is not given), or a resident receives partial tablets or single dose ampules (or it is not given), or the medication needs to be wasted, the medication shall be destroyed and may not be returned to the container .12. Medication has to be destroyed if the packing has been compromised. 13. All discontinued controlled drugs will be collected and should be broken down as best as possible. 34410 5. R73 is a [AGE] year-old female with cognition intact as per the Minimum Data Set (MDS) dated [DATE]. On 02/18/25 at 10:00 AM, R73 was at the nurse's station, and V3 (Licensed Practical Nurse/LPN) administered her medications. R73 asked for her hemorrhoid medicine, and V3 stated that he didn't have that to administer. On 02/18/25 at 10:12 AM, V3 (LPN) stated that R73's hemorrhoid cream is an over-the-counter medicine, and he told his supervisor a couple of days ago (V3 was off yesterday). V3 added that rectal cream is not available to administer as the resident (R73) requested. On 02/19/25 at 11:04 AM, R73 stated, I was impacted yesterday, and there was little blood around my rectum, and that's why I asked for my hemorrhoid medication yesterday. Record review on Physician Order Sheet (POS) dated 02/14/25 documented external cream (Hydrocortisone, rectal cream) to apply to the affected area topically every 6 hours for hemorrhoid pain/discomfort. On 02/19/25 at 09:33 AM, V2 (Director of Nursing/DON) stated that R73's rectal cream is an over-the-counter medication and is not covered under her insurance. V2 added that the medicines should be available for residents. A review of the facility-provided Medication on Admission policy (revised in December 2012) documented: Upon admission or re-admission, obtain a list of medications that the resident is supposed to be taking; once completed and reconciled, fax the information to the pharmacy so that delivery, if needed, can be arranged at their end. Information about the medication shall include but not be limited to: 1. Prescription medications, including those taken only as needed. 2. Non-prescription/over-the-counter medications, including those taken only as needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146168	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/21/2025
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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 48944 Based on observation, interview, and record review, the facility failed to safely administer a resident's extended-release antihypertensive medication. This applies to 1 out of 3 (R92) residents reviewed for medications in a sample of 30. The findings include: On 2/19/2025 at 8:15 AM during medication administration, V16 (Registered Nurse/RN) said she was going to administer R92's scheduled antihypertensive medication, Diltiazem ER (extended-release) 120 mg (milligrams) one tablet. V16 crushed and mixed R92's Diltiazem ER tablet with applesauce. V16 then administered R92's medication orally. On 2/19/2025 at 11:00 AM, V14 (Pharmacist) said R92's Diltiazem ER was an antihypertensive medication to lower the blood pressure. V14 said the tablet should have not been crushed because it lost its extended-release properties, and the dosage would have been absorbed quicker in the body. V14 also said the medication was listed in the Do Not Crush list which was provided to the facility. R92's Order Summary Report dated 2/19/2025 showed an order for diTIAZem HCl ER Oral Tablet Extended Release 24 Hour 120 MG (Diltiazem HCl) Give 1 tablet by mouth in the morning related to HYPERTENSIVE HEART DISEASE. The report showed another for May crush medications if indicated according to manufacturer's guidelines. Diltiazem Hydrochloride Extended-Release tablet manufacturing document dated 05/2019 said administration instructions were Tablet should be swallowed whole and not chewed or crushed. The pharmacy's document titled Meds That Should Not Be Crushed dated 2023, said Crushing pills can improve ease of administration, but some shouldn't be crushed. Crushing extended-release meds can result in administration of a large dose all at once. The document listed Diltiazem as a medication that should not be crushed. The facility's policy titled Administering Medications dated 03/2020, said Policy Statement Medications shall be administered in a safe and timely manner and as prescribed.