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	05/14/2026

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

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide residents and/or their POA (Power of Attorney) with a bed hold notice and written documentation for the reason of transfer to the hospital.This applies to 5 of 5 residents (R1, R2, R10, R129, R138) reviewed for transfers in a sample of 30.The findings include: 1.R1's progress note dated 1/23/26 at 4:56 PM shows: NOD (Nurse on Duty) noted a change in mental status of resident during her neuro checks. (R1) appeared confused and verbalized feeling nervous. Although (R1) remained alert and orientated x 4, (R1) appeared not at her baseline behavior. Vitals shown an elevated blood pressure from baseline of BP (Blood Pressure) 158/89 and respiratory rate increased to 28 breaths per minute from baseline. Oxygen saturation rate of 98%, Temperature—98.4 F (Fahrenheit), Heart Rate—104.medical doctor notified and orders to send to ER (Emergency Room) for evaluation. Orders carried out 911 was called for ambulance. ADON (Assistant Director of Nursing), DON (Director of Nursing), and POA (Power of Attorney) notified. (R1) was picked up by ambulance around 4:30 PM and sent to ER. R1's progress note dated 1/24/26 at 3:20 AM shows: (R1) admitted at hospital. Diagnosis: sepsis. POA and DON notified. R1's progress note dated 1/26/26 at 2:09 PM shows: (R1) returned from hospital to facility by ambulance. (R1) is alert and orientated x 4. No complaints of pain. R1's progress note dated 2/1/26 at 1:48 PM shows: Observed reddened spots to both thighs, abdomen, back, bilateral upper extremities, no swelling to lips or tongue and no shortness of breath. updated medical doctor with new order to hold Cephalexin x 1 day and Alogliptin x 7 days, stat CBC (Complete Blood Count) and CMP (Comprehensive Metabolic Profile).Benadryl 25 MG (Milligrams) PO (By Mouth) every 8 hours PRN (As Needed), Prednisone 40 MG daily. R1's progress note dated 2/1/26 at 10:58 PM shows stat CBC and CMP results received and relayed to medical doctor with new order received to send (R1) to ER for medication evaluation.called ambulance. (R1) made aware. POA also called and updated regarding (R1)'s current status and impending transfer to hospital. Verbalized understanding and DON notified. R1's progress note dated 2/2/26 at 2:30 AM shows: Ambulance here and came to pick up (R1) to ER. (R1) alert and orientated x 3. Left at 1:45 AM. R1's progress note dated 2/2/26 at 4:19 AM shows: Writer called ER to get an update on (R1) and per ER operator, (R1) is admitted for pneumonia and dehydration. Medical doctor notified. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R1's progress note dated 2/3/26 at 5:50 PM shows: (R1) arrived in facility in an ambulance and was accompanied by a paramedic who was pushing her in a wheelchair. Review of R1's electronic medical record shows there was nothing mentioned in the progress notes that the nurse or other staff member gave R1 a bed hold notice. It does not mention that the written documentation for the reason for transfer was given to R1 or their POA. Nothing was uploaded under documents/forms tab in the medical record. R1's MDS dated [DATE] shows she is cognitively intact. On 5/13/26 at 12:31 PM, R1 stated she was never given a bed hold notice or anything in writing for the reason of transfer. 2.R10's progress note dated 2/12/26 at 9:30 AM shows: (R10) was complaining of chest pain radiating to her left side towards her back. (R10) also stated she feels short of breath. 911 was called and (R10) left to ED (Emergency Department) via ambulance. Medical doctor, POA and DON notified. R10's progress note dated 2/13/26 at 8:31 AM shows: Per nurse on duty, R10 is admitted for PE (Pulmonary Embolism). R10's progress note dated 2/16/26 at 3:00 PM shows: Around 2:35 PM, readmitted a [AGE] year old Caucasian female via ambulance per stretcher from hospital. R10 has a discharge diagnosis of pulmonary embolism and pericardial effusion. Review of R10's electronic medical record shows there was nothing mentioned in the progress notes that the nurse or other staff member gave R10 a bed hold notice. It does not mention that the written documentation for the reason for transfer was given to R10 or their POA. Nothing was uploaded under documents/forms tab in the medical record. R10's MDS dated [DATE] shows she is cognitively intact. On 5/13/26 at 12:53 PM, R10 stated she was never given a bed hold notice or anything in writing for the reason of transfer. On 5/12/2026 at 11:04 AM, V2 (DON—Director of Nursing) stated, she didn't have any bed hold notices for R1 and R10. V2 stated they were not done. She stated we don't notify the residents or their families in writing about the transfer to the hospital. We usually just call their POA (Power of Attorney). I saw in the progress notes that the nurses didn't chart that it was given. Facility's policy titled Transfer and Discharge (including AMA/Against Medical Advice) dated 10/2/25 shows: 11. Emergency Transfers to Acute Care—G. Provide a notice of transfer and the facility's bed hold notice policy to the resident and representative as indicated. Facility's policy titled Bed Hold Notice dated 10/1/25 shows The facility will provide written information to the resident and/or the resident representative regarding bed-hold practices, both well in advance and at the time of a transfer for hospitalization or therapy of therapeutic leave. 3. The facility will keep a signed and dated copy of the bed-hold notice information given to the resident and/or resident representative in the resident's file and/or medical record. 3. On 05/13/26 at 10:33 AM, R129 said she went to the hospital on [DATE], and the facility did not provide her with a bed hold notification. R129 said she made her own medical decisions, and the facility did not explain to her the bed would be available upon return. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R129's face sheet showed she was admitted to the facility with diagnoses including type 2 diabetes mellitus, major depressive disorder, hypertension, attention-deficit hyperactivity disorder, rheumatoid arthritis, osteoarthritis, chronic pain syndrome, fibromyalgia, restlessness and agitation. R129's MDS (Minimum Data Set) dated 02/16/26 showed R129 was cognitively intact. R129's census showed she was admitted to the hospital on [DATE]. The facility was unable to provide a copy of the written bed hold notification provided to the resident upon her transfer to the hospital. 4. On 05/12/26, R138's medical record showed she was admitted to the hospital on [DATE]. As of 05/14/26, the facility was unable to provide a copy of the written bed hold notification provided to the resident upon her transfer to the hospital. R138's face sheet showed she was admitted to the facility with diagnoses including major depressive disorder, osteoporosis, osteoarthritis, lack of coordination, need for assistance with personal care, abnormalities of gait and mobility, low back pain, paranoid schizophrenia, and unsteadiness on feet. R138's census sheet shows she was transferred to the hospital on [DATE]. 5. R2' s face sheet documents admission date of 11/20/25. Diagnoses include non-alcoholic steatohepatitis, hypertension, type II diabetes mellitus, cirrhosis of liver, polyosteoarthritis, metabolic encephalopathy, bipolar disorder, depression, anxiety disorder, and schizoaffective disorder. MDS dated [DATE] documents she has intact cognitive functions. R2's Progress Notes dated 5/10/26 at 17:50 written by V3 (RN-Registered Nurse) documented R2 was sent out to a local hospital with paramedics. Further review of R2's EMR (Electronic Medical Record) documents R2 was also sent out to a local hospital on [DATE], 1/17/26, 2/26/26, 3/17/26 and 4/30/26. There was no documentation on R2's EMR showing a bed hold notice was done for all R2's hospitalizations. R2's EMR also did not show that written documentation for the reason for transfer was given to R1 or her POA for each of her hospitalizations. On 5/13/26 at 2:32 PM V3 said she was the nurse who discharged R2 to hospital on 5/10/26. She said R2 was admitted for diagnosis of cystitis. She said R2 is still in the hospital. V3 said she did not do a bed hold notice on the day she was sent to the hospital. She said she has never provided any written documentation to a resident or family member about reason for transfer.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to offer and provide snacks to residents at bedtime.This applies to 5 of 5 residents (R25, R65, R82, R94, R100) reviewed for bedtime snacks in a sample of 30.The findings include:R25's face sheet documents admission date of 12/28/25. Diagnoses include bipolar disorder, schizoaffective disorder, anxiety disorder, chronic obstructive pulmonary disease, hyperlipidemia, Schizophrenia, hypertension, and peripheral vascular disease. MDS (Minimum Data Sheet) dated 4/20/26 documents he has intact cognitive functions. R65's face sheet documents admission date of 9/25/23. Diagnoses include major depressive disorder, schizoaffective disorder, psychosis, hypertension and chronic kidney disease, stage II. MDS dated [DATE] documents she has intact cognitive functions. R82's face sheet documents admission date of 11/14/24. Diagnoses include chronic kidney disease, hypothyroidism, anxiety disorder, polyneuropathy, osteoarthritis, bipolar disorder, hypertension, and depression. MDS dated [DATE] documents she has intact cognitive functions. R94's face sheet documents admission date of 11/5/20. Diagnoses include bipolar disorder, psychosis, major depressive disorder, anxiety disorder, chronic obstructive pulmonary disease, arrythmia, hypothyroidism, hyperlipidemia, mood disorder, and delusional disorder. MDS dated [DATE] documents that she has intact cognitive functions. R100's face sheet documents admission date of 8/25/16. Diagnoses include polyneuropathy, major depressive disorder, Charcot's joint, atherosclerosis, multiple sclerosis, osteoporosis, anxiety disorder, peripheral vascular disease, and neuromuscular dysfunction of bladder. MDS dated [DATE] documents he has intact cognitive functions. On 5/13/26 at 10:00 AM, during the special Resident Council Meeting held during survey, R25, R65, R82, R94 and R100 said bedtime snacks are only given to some residents. They said snacks are given with their dinner trays. They said bedtime snacks are not provided to all residents. They said bedtime snacks are only provided to residents with physician's order. They said the facility used to call all residents down to the dining room for bedtime snacks but stopped doing it approximately two years ago. They said if they want snacks, they must purchase it from the activity table. They said snacks are not complimentary. They said if they do not get a snack, they are hungry between dinner and breakfast time.Separate interviews with V5 (RN-Registered Nurse) and V6 (RN) on 5/14/26 between 11:50 AM to 12:00 PM said bedtime snacks are placed on resident's meal tray during dinner. They said staff do not offer snacks.On 5/14/26 at 12:05 PM V7 (Dietary Services Manager) said bedtime snacks are placed on dinner tray for people with orders and for people who have diagnosis of diabetes mellitus. She said for the rest of the residents, it is given upon request. She said if a resident requests for bedtime snacks, she consults with the dietician whether she can give them bedtime snacks or not. She said bedtime snacks are important to stabilize blood sugar and to provide added nutrition.On 5/14/26 at 12:15 PM V2 (DON-Director of Nursing) said bedtime snacks go out with dinner trays. She said staff do not routinely offer bedtime snacks. She said staff should offer bedtime snacks to support better rest. Review of R25, R65, R82, R94 and R100's POS (Physician Order Sheet) shows they have no order for snacks at bedtime.Facility Policy and Procedure titled Nourishments (Night -Time Snacks) dated 2021 documents the following: Policy: Nourishments will be provided to the clients at approximately bedtime. Procedure: Food and nutrition services will deliver the bedtime nourishment (snack) as planned on the cycle menu to the nursing units after the evening meal. Nursing will distribute the bedtime nourishments.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview, and record review, the facility failed to provide a comfortable water temperature in the shower. This applies to 1 resident (R82) reviewed for homelike environment in a sample of 30 residents.The findings include:On 5/13/26 at 10:07 AM, R82 said the shower in the hallway that she likes to use does not have hot water. R82 said she has mentioned it in past resident council meetings, but it has yet to be fixed. On 5/14/26 at 12:06 PM, R82 said the shower temperature has been cold for over a year. R82 said she prefers to take showers in that shower room because it is more private, but it is uncomfortable and she can't sit under the water long to enjoy it, so she tries to get in and out quickly. On 5/14/26 at 10:49 AM, V10 (Maintenance Director) said R82 told him the water was not getting hot enough in the shower, but he checked the temperature and it was okay. V10 said hot water temperatures should range between 100-110 degrees F (Fahrenheit). On 5/14/26 at 10:52 AM, V10 checked shower temperature and let the water run for 6 minutes to see how hot it would get when turned all the way towards hot. The highest water temperature registered on thermometer was 93 degrees Fahrenheit. On 5/14/26 at 11:01 AM, V10 provided the Logbook Documentation from his previous temperature measurements and noted there was no space to record the shower temperature in R82's particular shower. The Logbook Documentation only has one space to record a temperature for that room, but the room has a shower and a sink to be tested.R82's MDS (Minimum Data Set) dated 4/29/26 shows her cognition is intact. R82's Care Plan initiated 11/14/24 shows she needs supervision with showers for safety and interventions include staff to assist with adjusting water temperature to a comfortable temperature as needed.The facility's policy titled, Safe Water Temperatures dated 10/1/25 states, Policy: The Facility will maintain appropriate water temperatures in all resident care areas.Procedure:.4. Water temperatures available to residents at shower, bathing, and hand washing facilities will be maintained at safe temperatures.6. Water temperatures will be set to.100-110 degrees F.The facility's policy titled, Homelike Environment last revised March 2020 states, Policy Statement: Residents are provided with a safe, clean, comfortable, and homelike environment.Policy Interpretation and Implementation: 1. The staff shall provide person-centered care that emphasizes the residents' comfort.personal needs and preferences. 2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, home-like setting. These characteristics include:.g. comfortable room and water temperatures.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on interview and record review the facility failed to offer and assist resident to participate in activities of her interest and preference.This applies to 1 of 1 residents R109 reviewed for activities in a sample of 30.Findings include:05/14/2026 at 1:53 PM, R109 stated it makes her angry not being able to participate in activities. R109 stated she likes music, trivia and would like to exercise but staff is too busy to assist her. R109 stated she can't participate in activities like bingo the staff offers to her because she is blind. R109 stated she doesn't always know what activities are available because no one reads the activity schedule to her. R109 stated there was a previous activity that staff left her in the activity area after the activity was over. R109 stated a housekeeper heard her scream and assisted her back to her room.05/13/2026 at 3:21 PM. V14 RN (Registered Nurse) stated R109 is mostly in her room sleeping.On 05/14/2026 at 11:08 AM, V9 Activities Director stated R109 likes music related activities and going outside. V9 stated activities staff see R109 every other day for bedside activities.05/14/2026 on 1:13 PM, V9 Activities Director stated the activities that have been provided to R 109 are room visits that consists of staff assist her to choose her meal selections and her POA (Power of Attorney) visits. V9 stated there was an activity R109 that was left behind in the activity area after the activity was over. V9 stated during group activities there isn't one staff member responsible for assisting R109 with the activity.R109's March 2026 activity calendar consisted of five room visits and one group activity. R109's April 2026 activity calendar consisted of six room visits and six group activities for the month. May 1st - 14th 2026, R109's three room visits.R109's care plan includes stated R109's vision has been assessed to be severely impaired. R109 tends to isolate in her room, and she needs staff assistance and encouragement to attend and participate in facility activities. R109 needs staff assistance to review the activity schedule, getting to / from facility activities and assistance with set up and program participation.Interventions include as R109 for advice on the best program adaptations, seating, visual orienting cues. Guide R109s hand, describe program and offer tactile, olfactory, and auditory experiential opportunities with programs. Orient R109 to surroundings by introducing self, describing location and surroundings / introducing to peers seated close by resident.The Facility policy Activities dated 10/01/25 states it is the policy of the facility to provide an ongoing program to support residents in their choice of activities based on their assessment, care plan and preferences. Facility sponsored group, individual, and independent activities will be designed to meet the interest of each resident, as well as support their physical, mental and psychosocial wellbeing. Activities will encourage both independence and interaction within the community. Special considerations will be made for developing meaningful activities for residents with dementia and / or special needs.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to properly store medications for residents who were not assessed to keep medications at bedside.This applies to 3 of 3 residents (R31, R43, R97) reviewed for medication storage in a sample of 30.The findings include: 1. On 05/12/26 at 9:55 AM, R31 had an Anoro Ellipta 62.5 mcg/25 mcg (Micrograms) on his bedside table. On 05/13/26 10:46 AM, R31 was sitting at the bedside and said he had emphysema, which he used an inhaler to treat. R31 opened his top drawer and pulled out the Anoro Ellipta inhaler. R31 said he got the inhaler from the nurse and would administer it by himself. R31's face sheet showed he was admitted to the facility with diagnoses including dementia, schizoaffective disorder, bipolar disorder, depression, epilepsy, cocaine abuse, delusional disorders, and chronic bronchitis. R31's MDS (Minimum Data Set) dated 04/14/26 showed R31 had mild cognitive impairment. R31's POS (Physician Order Sheet) did not show an order for R31 to store medications at the bedside. R31's Care Plan did not show any care plans regarding medication storage. The facility was not able to provide an assessment for R31 to store medications at his bedside. On 05/13/26 at 11:45 AM, V3 (RN/Registered Nurse) said she was the nurse for R31. V3 said none of her residents were allowed to keep their medications in their room. V3 said they were supposed to stay and watch the residents administer their medications. V3 said they do not store medications in the residents' rooms because the residents could be confused, or may not know how to administer it, or other residents could come into their rooms and take their medication. V3 said if a resident was alert, they would need to get an order from the doctor to keep the medicine in the room. V3 said the medication should also be in a locked drawer. On 05/13/26 at 11:51 AM, V4 (RN) said the residents were not allowed to keep medications at the bedside. V4 said if a resident wanted to keep it at their bedside, they would need to get an order from the doctor and make sure it was in a locked drawer. V4 said the doctor would need to determine if the patient was capable of administering the medication safely. V4 said the nurses should still watch the residents administer the medications even if they had been assessed to self-administer, as it needed to be signed off on the eMAR (Electronic Medication Administration Record). On 05/13/26 at 11:55 AM, V2 (DON/Director of Nursing) said they did not have any residents who were allowed to keep medications at the bedside. V2 said there was an assessment form they used to determine if the resident was safe to keep the medication at bedside, and then an order needed to be provided by the doctor. V2 said the medication should also be locked up to keep out of other residents' reach. V2 said the residents also needed to notify their nurse so the nurse could document it in the eMAR. The facility's Medication Storage policy dated 10/01/25 showed It is the policy of this facility to ensure that all medications housed on our premises are stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations, in sufficient quantities to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security.All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls.During a medication pass, (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. 2. On 05/12/2026 at 10:35 AM, a fluticasone propitiate / salmeterol 100/ 50 discus in front of her on her over bed table. R43 stated the nurses always leave it there for her to use. R43's current physician orders lists fluticasone/ salmeterol aerosol powder breath activated 100/50 MCG / dose. In inhalation inhale orally every twelve hours 3. On 05/12/2026 at 11:14 AM, Nystatin 60grams prescribed for R119 dispensed 2/24/26 was on R97's nightstand. R97's current physician orders includes nystatin powder 100000 units / gram apply to skin folds topically as needed for redness related to moisture apply twice daily. R119's nystatin order start date of 2/24/26 apply to inner buttocks every night shift until healed order stop date of 3/10/26

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. Based on observation interview and record review the facility failed to provide built up eating utensils to support a residents independent eating.This applies to 1 or 1 residents R3 reviewed for meal assistive devices in a sample of 30.Findings include:On 05/12/2026 at 12:09 PM, during the meal observation R3 struggled to feed herself by dropping her food on her chest. R3 stated she was having a hard time handling her spoon to feed herself. R3's meal ticket list built up utensils for all meals.On 05/13/2026 at 12:18 PM, V8 CNA. (Certified Nursing Assistant) stated the meal trays are for the residents are set up by the CNAs. The CNA that prepares the meal tray and the CNA that delivers the tray to the resident are responsible to assure the tray s correct. If the resident does not have the utensils they need, they will struggle to eat their meal.On 05/13/2026 at 4:15 PM, V2 DON (Director of Nursing) stated residents are assessed by speech or occupational therapy for built up utensils. Residents are not able to eat independently if they don't have utensils when they are eating. The CNA building the tray should comply with what is on the meal card. The CNA delivering the resident's tray should double check to make sure the tray is correct. R3's physician diet order dated 1/14/26 includes no added salt low concentrated sugar diet pureed texture, regular thin consistency built up utensils divided plate.The facility policy Adaptive Feeding Equipment dated 10/01/25 states residents who require assistance with eating will be assessed to determine their ability to safely and independently participate in dining activities to the highest practicable level. Adaptive equipment and utensils will be placed on the resident's meal tray at each meal as indicated.