STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510065	A. BUILDING: _____ B. WING _____	C 11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUSTWELL LIVING OF SPRINGFIELD	2451 W WHITE OAK DRIVE SPRINGFIELD, IL 62704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comment Facility Reported Incident IL198657 Violations 295.5000 f) 2) 295.6000 a) 13)	A 000		
A5000	Section 295.5000 Medication Reminders, Supervision of Self Med This Regulation is not met as evidenced by: Type 2 Violation Section 295.5000 Medication Reminders, Supervision of Self-Medication, Medication Administration and Storage f) If an establishment provides medication administration or supervision of self-administered medication, the establishment's medication policies and procedures shall be approved by a physician, pharmacist, or registered nurse and shall address: 2) Storing and controlling medication; Based on record review and interviews, the establishment failed to follow policies regarding accounting for controlled medications through shift changes for one of three residents sampled. (R1) This failure has a substantial probability to cause harm to the resident or residents. Findings include: According to R1's current physician's order sheet and medication administration record, R1 has an order for Morphine Sulfate solution that reads,	A5000		

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A5000	Continued From page 1	A5000		

"100/50ML Give 0.25ML (5 Mg) by mouth every two hours as needed for moderate pain / air hunger."

Facility incident report for R1 reads, "Controlled substance discrepancy - on Nov. 21st at 7am liquid Morphine found to be less than when delivered . No medication was given from the bottle to the resident. Confirmed with Hospice, corporate office made aware. Investigation initiated. Resident (R1) unaffected. Hospice and Hospice MD notified."

On 11/22/25 at 11:20 A.M., E1 (Executive Director) confirmed that through their investigation, a bottle of 30 ML of Morphine Sulfate solution for R1 was delivered from the pharmacy to E3 (LPN) on 11/20/25 on second shift around 8:00 P.M.. E3 left at around 11 P.M. when E4 (LPN Third shift) came on duty. E4 left in the morning around 7:00 A.M. when E5 (LPN First shift) came on duty. E5 noted that there was only 19 ML in R1's bottle of Morphine Sulfate and E5 reported it to E2 (Health Services Director).

On 11/24/25 at 8:52 A.M., E3 stated that on 11/20/25 at 8:00 P.M. the pharmacy did deliver a 30 ML bottle of Morphine Sulfate solution for R1. E3 stated that she did not administer any to R1 that shift and reported off to E4 at around 11 P.M.. E3 stated that she did narcotic count with E4 and that the Morphine Bottle in question was counted. E3 denies taking the missing 11 ML of Morphine Sulfate Solution.

On 11/23/25 at 6:20 P.M., E4 stated she did come on duty at 11:00 on the evening of 11/20/25 and did the narcotic count with E3. E4 stated that the Morphine Sulfate solution in question was not with all the narcotics and she did not see it. E4

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A5000	Continued From page 2	A5000		

stated that she worked from 11:00 P.M. until 7:00 A.M., when E5 came in for first shift. E4 stated that they did not do a narcotic count together because she was late going to school. E4 denies taking the missing 11 ML of Morphine Sulfate solution.

On 11/24/25 at 9:15 A.M., E5 stated that she came on duty around 7:00 A.M. on the morning of 11/21/25, when E4 was leaving. E5 stated she completed the narcotic count by herself because E4 had to leave for school. E5 stated it is facility policy that they are to count narcotics with the out going and incoming nurse together. E5 stated when she counted the narcotics by herself, she found R1's bottle of Morphine Sulfate solution in the back of the narcotic drawer and it should have been in the front. E5 stated that she then notice that there was 11 ML of Morphine Sulfate solution missing. E5 stated that she reported this to E2 immediately. E5 denies taking the missing 11 ML of Morphine Sulfate solution.

On 11/24/25 at 10:52 A.M., E1 stated that through their investigation, they can not determine who took R1's 11 ML of Morphine Sulfate solution. E1 confirms that staff did not follow the policy for "Accounting Controlled Drugs During Shift Changes". E1 confirmed that 11 ML of R1's Morphine Sulfate solution is missing and unaccounted for. E1 stated that the police have been notified.

The establishment policy for "Controlled Drugs Management Policy" reads, "2. Accounting Controlled Drugs During Shift Changes: b. The following process shall be followed during shift changes or transition of the keys: i) The outgoing person will review and sign the Narcotics Count Shift Change while the oncoming person

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A5000	Continued From page 3 performs an inventory count on the number of controlled drug containers/cards in the controlled drug drawer".	A5000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Type 2 Violation Section 295.6000 Resident Rights a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights: 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; Based on record review and interviews, the establishment failed to prevent the theft of a controlled medication for one of three residents sampled. (R1) This failure has a substantial probability to cause harm to the resident or residents. Findings include: According to R1's current physician's order sheet and medication administration record, R1 has an order for Morphine Sulfate solution that reads, "100/50ML Give 0.25ML (5 Mg) by mouth every two hours as needed for moderate pain / air hunger."	A6000		

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A6000	Continued From page 4 Facility incident report for R1 reads, "Controlled substance discrepancy - on Nov. 21st at 7am liquid Morphine found to be less than when delivered . No medication was given from the bottle to the resident. Confirmed with Hospice, corporate office made aware. Investigation initiated. Resident (R1) unaffected. Hospice and Hospice MD notified." On 11/22/25 at 11:20 A.M., E1 (Executive Director) confirmed that through their investigation, a bottle of 30 ML of Morphine Sulfate solution for R1 was delivered from the pharmacy to E3 (LPN) on 11/20/25 on second shift around 8:00 P.M.. E3 left at around 11 P.M. when E4 (LPN Third shift) came on duty. E4 left in the morning around 7:00 A.M. when E5 (LPN First shift) came on duty. E5 noted that there was only 19 ML in R1's bottle of Morphine Sulfate and E5 reported it to E2 (Health Services Director). On 11/24/25 at 8:52 A.M., E3 stated that on 11/20/25 at 8:00 P.M. the pharmacy did deliver a 30 ML bottle of Morphine Sulfate solution for R1. E3 stated that she did not administer any to R1 that shift and reported off to E4 at around 11 P.M.. E3 stated that she did narcotic count with E4 and that the Morphine Bottle in question was counted. E3 denies taking the missing 11 ML of Morphine Sulfate Solution. On 11/23/25 at 6:20 P.M., E4 stated she did come on duty at 11:00 on the evening of 11/20/25 and did the narcotic count with E3. E4 stated that the Morphine Sulfate solution in question was not with all the narcotics and she did not see it. E4 stated that she worked from 11:00 P.M. until 7:00 A.M., when E5 came in for first shift. E4 stated that they did not do a narcotic count together	A6000		

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A6000	Continued From page 5	A6000		

because she was late going to school. E4 denies taking the missing 11 ML of Morphine Sulfate solution.

On 11/24/25 at 9:15 A.M., E5 stated that she came on duty around 7:00 A.M. on the morning of 11/21/25, when E4 was leaving. E5 stated she completed the narcotic count by herself because E4 had to leave for school. E5 stated it is facility policy that they are to count narcotics with the out going and incoming nurse together. E5 stated when she counted the narcotics by herself, she found R1's bottle of Morphine Sulfate solution in the back of the narcotic drawer and it should have been in the front. E5 stated that she then notice that there was 11 ML of Morphine Sulfate solution missing. E5 stated that she reported this to E2 immediately. E5 denies taking the missing 11 ML of Morphine Sulfate solution.

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