STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510109	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUSTWELL LIVING AT CHERRYVALE	1545 TEMPLE LANE ROCKFORD, IL 61112

(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: (01/14/2026) IL00199725: 295.4010 a) b) 3) d) g) 1) A) C) 2) 3) h) i) 295.6000 a) 1) 5) 13)	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: TYPE 1 VIOLATION Section 295.4010 Service Plan 295.4010a)b)3)d)g)1)A)C)2) 3)h)i) a) Based on the physician's assessment and establishment evaluation (see Section 295.4000), a written service plan shall be developed and mutually agreed upon by the establishment and the resident. (Section 15 of the Act) The establishment shall respect and accept the resident's choices regarding the service plan. b) The service plan shall be developed by: 3) A registered nurse, if the resident is receiving nursing services or medication administration, or is unable to direct self-care. d) The service plan, which shall be reviewed annually, or more often as the resident's condition, preferences, or service needs change, shall serve as a basis for the service delivery contract between the provider and the resident (see Section 295.2030). (Section 15 of the Act)	A4010		

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A4010	Continued From page 1 g) Service plans shall address: 1) The level of service the resident is receiving, including: A) assistance with activities of daily living; C) special accommodations for the resident; 2) The amount, type, and frequency of health-related services needed by the resident; 3) Staff responsible for the provisions of the service plan; h) The service plan shall include all support services provided or arranged for by the establishment. i) Nothing in this Part limits a resident's ability to direct his or her own care and negotiate the terms of his or her own care. Residents have the right to refuse certain services or approaches that would otherwise be recommended based on the physician's assessment if the resident has received clear information regarding the risks and benefits of such a choice and the choice does not put other residents or staff at risk. Disclosure of the risks of refusing services or approaches must be documented in the service plan. This regulation is NOT MET as evidenced by: Based on interview and record review, the establishment failed to follow a resident's service plan by not transferring the resident with a mechanical lift and two staff members to prevent	A4010		

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A4010	Continued From page 2	A4010		

an accident or injury. This failure applied to one (R1) of three residents reviewed for this requirement .
This failure resulted in a significant head injury and left hip fracture.
This failure has the substantial probability to affect all residents. This failure creates a substantial probability of severe harm to a resident or residents

Findings include:

Review of R1's medical record showed a move-in date of 01/29/2024 and was admitted into hospice on 03/21/2024. Past medical history included but not limited to Alzheimer's, dementia, fall, pelvic fractures, adult failure to thrive and hypertension.

R1's service plan detail dated 02/06/2025 reads in part: requires total care from staff with any bathroom needs due to incontinence; requires staff assistance with all dressing and grooming needs, depending on confusion, at times will help push her arms through shirt sleeves or pull shirt down over her head, needs total assist with dressing her lower body; hi/low bed and broda chair; requires staff assistance of two for transfers, to get out of bed and chair or transporting from bed to chair; at risk for falls due to disease process, diagnoses, poor safety awareness, and history of falls. Interventions included (but not limited to) bed in low position and fall mats next to bed.

Review of establishment investigation/incident reports with incident date of 01/14/2026 revealed that R1 is non-ambulatory, dependent for transfers, and required a two-person assist with mechanical lift per comprehensive care plan. On day of incident, E3 (Certified Nursing Assistant)

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A4010	Continued From page 3	A4010		

stated she and E4 (Certified Nursing Assistant) transferred R1 from her broda chair to the bed. After the transfer, E3 provided peri care to R1 and during care, R1 "rolled over and fell from the bed onto the floor". R1 sustained a laceration to the left forehead with bruising and was sent to the emergency room for further evaluation. R1 received staples to the head laceration and was noted to have a left hip fracture. Interview with E4 revealed that she did not assist E3 to transfer R1 into bed. Further investigation findings concluded that E3 failed to follow R1's care plan for transfer and did not implement necessary fall-prevention interventions, including proper bed positioning and supervision during care. E3 was terminated upon completion of the investigation.

Review of R1's after visit summary dated 01/14/2026, she was treated at the hospital post fall for a forehead laceration and diagnosed with a "closed fracture of left hip".

On 02/20/2026 at 12:42 PM, E4 (Certified Nursing Assistant) said verbatim during interview regarding R1's incident: at around 2:30-3:00 PM, she saw E3 (Certified Nursing Assistant) pushing R1 in her broda chair to her room. E3 asked for help over the radio, and E6 (Certified Nursing Assistant) responded back asking if she needed help, but E3 did not respond. E4 said she did not assist E3 with R1's transfer. E4 added that E3 had the personality where she will not ask for help if she doesn't like you. At 12:47 PM, E4 said when she walked into R1's room, R1 was in bed, wearing only a brief and she was bleeding "a lot" from her head. E3 was standing by the foot of the bed, picking up the soiled linens and the incontinent brief. The bed was in a high position. E4 then said that R1 was a mechanical lift for transfers and staff are to always have two people

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A4010	Continued From page 4	A4010		

when transferring with the lift so the resident can be safely transferred.

On 02/20/2026 at 01:05 PM, E3 (Certified Nursing Assistant) said verbatim during interview regarding R1's incident: R1 was in her broda chair, and she was taking R1 to her room to change her brief. E3 said she called over the radio for help when she got to R1's room, but nobody answered her back. E3 said that R1 is a mechanical lift for transfers, and they are supposed to have two staff present to transfer. E3 said at times when they are short staffed, they transfer residents by themselves then indicated they were not short staffed on the day of incident. E3 then said she transferred R1 from the broda chair to the bed by herself using the mechanical lift. She took off R1's pants and began giving providing personal care. E3 said while she was cleaning R1 up, E3 turned to put something into the garbage can that was next to the bed when R1 flipped out of the bed onto the side she was standing on. E3 said she couldn't catch her. R1 fell to the floor and landed on her buttocks. Everything happened so quick. E3 said she thought R1 hit her head on the bed because she had a cut on her head to her left side that was not bleeding but not a lot. The nurse was called and came to evaluate R1. After the nurse finished, E3 said she and E6 put R1 back into bed without using the mechanical lift. They lowered the bed to the floor and two-assisted her back into bed. At 1:17 PM, E3 said she was suspended after she gave her statement and was terminated because she used the lift without having another person present.

On 02/20/2026 at 02:08 PM, E2 (Health Services Director) said verbatim during interview regarding R1's incident: R1 was a mechanical lift for

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A4010	Continued From page 5 transfers with two persons assist. E2 then said initially, E3 said she transferred R1 from the broda to bed with another staff member, E4. E2 then said whether E3 used the lift is unknown, but however she transferred R1 that day, it was done by herself and incorrectly. E3 had stated that R1 rolled off the bed while she was providing care and kept assisting that another staff member had assisted her with the transfer but nobody else was in the room when R1 rolled out of bed. E2 added that her expectation is for staff to transfer residents with the correct transfer status per service plan for resident safety. E2 then indicated that E3 was terminated for failure to adhere to R1's service plan and company policy. At 03:40 PM, E2 said staff should use the resident's correct transfer status, including with post fall transfers then said if a resident requires the use of a mechanical lift for transfers, staff should use the lift to get them up. Care Plan policy last reviewed 10/2025 that was provided by facility on 02/20/2026 reads in part: Each resident's care plan should address areas of needed and preferred services, including resident care services, health-related services, meals, housekeeping, activities, and special services if appropriate. Each resident should receive service and supervision based upon the resident's individual needs and preferences. These needs and preferences should be determined through the initial assessment and service planning process in the resident's care plan ... Care plan will be done at move-in or before move-in, so that a determination can be made on appropriateness of the potential move-in and an accurate level of care can be established. Subsequent care plans will be completed at the cadence set by stage regulation. The provision of services to residents includes (but not limited to)	A4010		

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A4010	Continued From page 6 basic or core services provided to all residents and supplemental services to meet the needs and preferences of individual residents ... Mechanical Lifts for Resident Transfers Policy last reviewed 10/2024 that was provided by facility on 02/20/2026 reads in part: This community will adhere to manufacturer's instructions for the use and maintenance of any mechanical lift device. The safety of both the resident and of the assisting team members will be maintained. The goal is to prevent accidents and injuries to residents and team members. Any team member assigned to use a mechanical lift will receive appropriate training on its safe operation. If a team member fails to utilize the lift when its use is a part of the resident's documented plan of care, he or she will be subject to disciplinary action. Procedures (not limited to): when it is determined that a mechanical lift would be beneficial in the safe lifting or transferring of a particular resident, as evaluated by the community nurse, medical provider or therapy personnel, that information will be included on the resident's individualized service plan ...Two team members will be present whenever the mechanical lift is in use ...Any team member who observes a mechanical lift being used incorrectly or without a second person and does not report the safety violation to the HSD or ED, will be subject to disciplinary actions. If a team number does not operate the lift in accordance with their training and with community policy or fails to use the mechanical lift for a resident whose individualized service plan indicates that it is to be used or uses the mechanical lift without a second team member present, the team member will be subject to disciplinary action up to and including termination.	A4010		

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A6000	Section 295.6000 Resident Rights	A6000		

This Regulation is not met as evidenced by:
TYPE 1 VIOLATION

Section 295.6000 Resident Rights
295.6000

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:

1) The right to live in an environment that promotes and supports each resident's dignity, individuality, independence, self-determination, privacy, and choice and to be treated with consideration and respect:

5) The right to receive the services specified in the service plan, to review and renegotiate the service plan at any time; and to be informed of the cost of the changes;

13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor;

This regulation is NOT MET as evidenced by:

Based on interview and record review, the establishment failed to ensure a resident's right to be in an environment that supports and promotes dignity, respect and is free from abuse or neglect; failed to ensure a resident was safely transferred and positioned in bed to avoid an accident or injury; and failed to follow their fall, mechanical lift and service plan policies. This failure applied to

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one (R1) of three residents reviewed for falls but has the substantial probability to affect all residents in the establishment.

This failure resulted in R1 sustaining a head laceration and a left hip fracture that required emergent treatment and evaluation.
This failure has the substantial probability to affect all residents. This failure creates a substantial probability of severe harm to a resident or residents

Findings include:

Review of R1's medical record showed a move-in date of 01/29/2024 and was admitted into hospice on 03/21/2024. Past medical history included but not limited to Alzheimer's, dementia, fall, pelvic fractures, adult failure to thrive and hypertension.

R1's service plan detail dated 02/06/2025 reads in part: requires total care from staff with any bathroom needs due to incontinence; requires staff assistance with all dressing and grooming needs, depending on confusion, at times will help push her arms through shirt sleeves or pull shirt down over her head, needs total assist with dressing her lower body; hi/low bed and broda chair; requires staff assistance of two for transfers, to get out of bed and chair or transporting from bed to chair; at risk for falls due to disease process, diagnoses, poor safety awareness, and history of falls. Interventions included (but not limited to) bed in low position and fall mats next to bed.

Review of establishment investigation/incident reports with incident date of 01/14/2026 revealed that R1 is non-ambulatory, dependent for transfers, and required a two-person assist with

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mechanical lift per comprehensive care plan. On day of incident, E3 (Certified Nursing Assistant) stated she and E4 (Certified Nursing Assistant) transferred R1 from her broda chair to the bed. After the transfer, E3 provided peri care to R1 and during care, R1 "rolled over and fell from the bed onto the floor". R1 sustained a laceration to the left forehead with bruising and was sent to the emergency room for further evaluation. R1 received staples to the head laceration and was noted to have a left hip fracture. Interview with E4 revealed that she did not assist E3 transfer R1 into bed.

Investigation Report findings revealed: caregiver failed to follow the resident's comprehensive care plan, which required a two-person assist and use of [mechanical lift; care giver did not implement necessary fall-prevention interventions, including proper bed positioning and supervision during care; caregiver's actions constitute neglect, defined IDPH regulations as failure to provide goods and services necessary to avoid physical harm, mental anguish, or illness; caregiver demonstrated negligent practice, directly contributing to the resident's fall and subsequent injury; investigation identified credible evidence that the caregiver attempted to influence other staff members to alter or falsify statements, compromising the integrity of the investigation; caregiver submitted a false or misleading statement, which is a violation of facility policy and regulatory expectations. The resident (R1) experienced actual harm, as evidenced by a fall with injury requiring emergency medical intervention. Due to the seriousness of the incident, the confirmed neglect, and the falsification concerns, the facility has determined that continued employment of [E3] presents a risk to resident safety. Request immediate termination

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A6000	Continued From page 10	A6000		

of employment upon completion of the investigation.

Review of R1's after visit summary dated 01/14/2026, she was treated at the hospital post fall for a forehead laceration and diagnosed with a "closed fracture of left hip".

On 02/20/2026 at 12:42 PM, E4 (Certified Nursing Assistant) said verbatim during interview regarding R1's incident: at around 2:30-3:00 PM, she saw E3 (Certified Nursing Assistant) pushing R1 in her broda chair to her room. E3 asked for help over the radio, and E6 (Certified Nursing Assistant) responded back asking if she needed help, but E3 did not respond. E4 said she did not assist E3 with R1's transfer. E4 added that E3 had the personality where she will not ask for help if she doesn't like you. At 12:47 PM, E4 said when she walked into R1's room, R1 was in bed, wearing only a brief and she was bleeding "a lot" from her head. E3 was standing by the foot of the bed, the bed was in a high position. E3 didn't say anything and E4 didn't say anything because she was in shock at what she saw. E4 then said she didn't know whether E3 tried to transfer R1 from the chair to the bed without using the lift and dropped her because sling was still neatly placed in the chair. She added that after staff transfer a resident with a mechanical lift, they usually just throw the sling on the chair and don't take the time to neatly place it back in the chair. E4 then said that R1 was a mechanical lift for transfers and staff are to always have two people when transferring with the lift so the resident can be safely transferred. E4 added that when she was in the hallway on her way to give her statement, she passed E3 who said to E4, "I told them you helped me with the transfer". E4 added that on two other occasions shortly after this, E3 had

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asked her to say she transferred R1 with E3 because E3 did not want to lose her job. E4 added that at no time did E3 say she felt bad about what happened to R1, she just acted like she didn't want to lose her job/benefits.

Review of E4's initial written statement post fall dated 01/14/2026 provided by establishment corroborated the above statement given by E4 during interview with surveyor on 02/20/2026 regarding the transfer and E3 asking E4 to give a false statement.

On 02/20/2026 at 01:05 PM, E3 (Certified Nursing Assistant) said verbatim during interview regarding R1's incident: R1 was in her broda chair, and she was taking R1 to her room to change her brief. E3 said she called over the radio for help when she got to R1's room, but nobody answered her back. E3 said that R1 is a mechanical lift for transfers, and they are supposed to have two staff present to transfer. E3 said at times when they are short staffed, they transfer residents by themselves then indicated they were not short staffed on the day of incident. E3 then said she transferred R1 from the broda chair to the bed by herself using the mechanical lift. She took off R1's pants and began giving providing personal care. E3 said while she was cleaning R1 up, E3 turned to put something into the garbage can that was next to the bed when R1 flipped out of the bed onto the side she was standing on. E3 said she couldn't catch her. R1 fell to the floor and landed on her buttocks. Everything happened so quick. E3 said she thought R1 hit her head on the bed because she had a cut on her head to her left side that was not bleeding but not a lot. The nurse was called and came to evaluate R1. After the nurse finished, E3 said she and E6 put R1 back into bed without

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using the mechanical lift. They lowered the bed to the floor and two-assisted her back into bed. At 1:17 PM, E3 said she was suspended after she gave her statement and was terminated because she used the lift without having another person present.

Review of E3's undated initial written statement post fall provided by establishment revealed that E3 indicated "a co-worker helped me transfer [R1] and while cleaning her she flipped out the bed onto the floor".

Review of E3's performance deficiency notification of dismissal dated 01/15/2026 reads in part: due to the evidence presented in the investigation, the allegation of neglect has been substantiated. As a result, E3 will be terminated effective immediately.

On 02/20/2026 at 02:08 PM, E2 (Health Services Director) said verbatim during interview regarding R1's incident: R1 was a mechanical lift for transfers with two persons assist. E2 then said initially, E3 said she transferred R1 from the broda to bed with another staff member, E4. E2 then said whether E3 used the lift is unknown, but however she transferred R1 that day, it was done by herself and incorrectly. E3 had stated that R1 rolled off the bed while she was providing care and kept assisting that another staff member had assisted her with the transfer but nobody else was in the room when R1 rolled out of bed. E2 added that her expectation is for staff to transfer residents with the correct transfer status per service plan for resident safety. E2 then indicated that E3 was terminated for failure to adhere to R1's service plan and company policy.

On 02/20/2026 at 2:22 PM, E5 (Licensed

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TRUSTWELL LIVING AT CHERRYVALE	1545 TEMPLE LANE ROCKFORD, IL 61112

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Practical Nurse) said verbatim during interview regarding R1's incident: she was called to R1's room by E3 and when E5 entered the room, R1 was on the floor next to the bed. She had a laceration to her head. She was crying and became distress when E5 was attempting to clean her up and assess her. R1 was trying to push E5 away. R1 couldn't indicate where the pain was, but she was winching in pain. At the time that E5 entered R1's room, only E3 and R1 were present. Bed was in high position. E5 asked E3 what happened and E3 said that R1 "lurched out the bed". E5 indicated she had never witnessed R1 lurch forward. After E5 assessed R1, she left the room to call hospice. E5 did not indicate whether she assessed R1's lower extremities for abnormalities. E5 went back to R1's room after contacting hospice, and said E6 (Certified Nursing Assistant) was in the room with E3 and R1 was in the bed. Hospice nurse was also present and said that R1 needs to go out for treatment of the head laceration. E5 indicated that R1 was a mechanical lift with two staff for the resident's safety. R1 was sent out to emergency room for the laceration that was closed with either sutures or staples and was diagnosed with a hip fracture.

On 02/20/2026 at 02:34 PM, E6 (Lead CNA) said verbatim during interview regarding R1's incident: at approximately 2:30-2:45 PM, she heard E3 ask for help in R1's room over the radio. E6 answered back and said she was on her way. When E6 walked into R1's room a few minutes later, R1 was on the floor and was bleeding from her head. The bed was at a high position, about waist level. R1 is a mechanical lift, and it was in the room. The sling was still in the broda chair. E6 added that from her observation, the sling was in place as it would be after a resident is transferred into

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the chair. Staff usually tuck the straps of the sling on the sides and back of chair and they were still that way. E6 indicated that when hospice provides a lift, it is for that resident and stays in the room. E6 said she didn't ask any questions. E3 just said that R1 "flipped out of the bed". Then E5 came into the room and went over to R1. She asked E3 what happened and E3 said R1 flipped out of the bed. E5 asked if E3 walked away at any time. E3 said she turned to put something into the garbage can then R1 flipped out of the bed. E6 indicated that E3 did not say how she initially got R1 into bed, and whether she used the lift or not. E6 then said after E5 assessed R1, she and E3, two-person lifted R1 off the floor and onto the bed. E6 said they lowered the bed to about knee level, then they each got on one side of R1 and lifted her onto the bed. E6 added that a gait belt was not used because there wasn't one in the room. E6 added that E5 did not tell them to get R1 up, they just got her up from the floor because E6 thought that's what they are supposed to do, get the resident off the floor. At that moment, E6 said she wasn't thinking about using the lift, she just wanted to get R1 up off the floor. She then said the lifts don't always go down low enough to the floor. At 02:43 PM, E6 said R1 had facial grimacing, but didn't recall whether she was crying or not. E6 said R1 was sent out to the emergency room and returned before she left at 10:00 PM. R1's daughter informed staff that her left hip was broken. E6 added there were times in the past that she knew E3 didn't ask for help with two assist transfers then indicated she didn't tell anyone but should have informed management. She added that E3 had a stubborn personality, and didn't like E6. At 2:48 PM, E6 said all mechanical lift transfers must have two staff present for the resident's safety. E6 also indicated that E4 came to her and said that E3 wanted E4

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to say that she was in the room for R1's transfer. E6 told E4 to just tell management the truth. E6 said she believed that E3 called for help after she had already transferred R1 by herself. E6 added that she didn't know if R1 fell during the transfer or if she actually did roll out of bed. She added that E3 was short with the E5 when she was asking E3 questions. E3 had said it was an accident and that accidents happen. E6 then said it seemed like E3 was more concerned with herself and not with R1.

On 02/20/2026 at 3:19 PM, E7 (Certified Nursing Assistant) said the assignment sheet indicates how a resident transfers and what assisted devices they use (walker, wheelchair). E7 then said they are supposed to use two staff members with a mechanical transfer for safety and after a fall, the nurse will assess the resident then will tell us if it's okay to get them up. E7 added that if a resident is a mechanical lift for transfers, they use the lift because they can't stand so the lift should be used even after a fall to get them up.

On 02/20/2026 at 03:40 PM, E2 (HSD) said staff should use the resident's correct transfer status, including with post fall transfers then said if a resident requires the use of a mechanical lift for transfers, staff should use the lift to get them up.

Undated Abuse, Neglect and Exploitation Policy-Illinois Communities Policy that was provided by facility on 02/20/2026 reads in part: This policy and Procedure applies to reporting of resident abuse, neglect and financial exploitation. The purpose of this policy is to outline guidelines, requirements and expectations of the community regarding abuse, neglect and financial exploitation ...Definitions (include but not limited to): Neglect is a failure to provide services, as

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A6000	Continued From page 16 outlined in the residency agreement ... Resident Rights Exhibit 11 dated 03/13/2025 that was provided by facility on 02/20/2026 reads in part: Sec.95. Resident rights. 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 (not limited to): (9) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; Emergency Resident Fall Response Policy last reviewed 10/2025 that was provided by facility on 02/20/2026 reads in part: ... The purpose of this policy is to outline guidelines, requirements, and expectations in these situations. For purposes of this policy, an emergency is defined as a serious, unexpected, and often dangerous situation requiring immediate action. Emergencies with falls may include but are not limited to: sudden change of condition with change in ability to walk after the fall, noted abnormality in extremity, lacerations (cuts) with profuse bleeding, altered level of consciousness (fainted), increased confusion, and/or an unwitnessed fall. Procedure: If the resident is suspected of having struck their face, head, or back of the neck, or the resident was witnessed striking their face, head, or back of the neck (even if no injuries are noted), IMMEDIATELY CALL 9-1-1, then notify your supervisor. Emergency personnel should be informed that the resident needs to be assessed for a possible closed head injury. If the evaluation reveals painful areas or bumps or the resident's limbs are in an unnatural position, encourage the resident to remain on the floor until an ambulance	A6000		

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A6000	Continued From page 17 arrives ...Do not move the resident. Use pillows or blankets, as needed, to make sure the resident is as comfortable as possible ...Perform a brief check of the resident to include feeling the elbows, shoulders, backs, hips, and knees ...	A6000		