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 02/05/2026

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 Original Complaint Investigation IL199915 - 295.2050a)b) IL199947 - 295.2050a)b) IL200027 - 295.2050a)b)	A 000		
A2050	Section 295.2050 Incident and Accident Reporting This Regulation is not met as evidenced by: Violation Type 1 Section 295.2050 Incident and Accident Reporting a) An establishment shall report to the Department an incident or accident that has a significant negative effect on a resident's health, safety or welfare. A significant negative effect shall be assumed whenever an unplanned or unscheduled visit to a hospital is necessary as a result of that incident or accident, treatment is provided, and follow-up care is required. b) The report shall be made by contacting the Department of Public Health Central Complaint Registry or by fax or by other electronic means, within 24 hours after the occurrence of the incident or accident. Based on observation, interview, and record review the establishment failed to notify the State Agency within 24 hours of an incident with injury, requiring hospitalization for one (R1) of three residents reviewed for incidents and accidents in the sample of four. This creates a substantial probability of severe harm to a resident or residents.	A2050		

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 02/05/2026

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
A2050	Continued From page 1 Findings include: The establishments undated Emergency Resident Fall Response Policy documents "An emergency is defined as a serious, unexpected and often dangerous situation requiring immediate action. Emergency situations 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 with profuse bleeding, altered level of consciousness, increased confusion, and/or an unwitnessed fall." This same policy documents "The Executive Director and/or Health Services Director is responsible for following state-specific reporting guidelines." The Universal Incident Report for R1 dated 1/25/26 documents that at 7:50 am Z1 (R1's) Family Member reported to E3 LPN/Licensed Practical Nurse that R1 had fallen and hit her head and Z1 picked R1 up off the floor. Upon E3 LPN assessment R1 was unresponsive and sent out to the local hospital. The establishment document dated 2/2/26 documents R1's incident occurred on 1/25/26 and was reported to the State Agency on 2/2/26 as "Late Submission" with the following documentation: "This letter serves as a follow-up to the incident involving (R1) on January 25, 2026. The initial report was not submitted within the required 24-hour timeframe, and this submission is being provided as soon as the oversight was identified. (R1) was transported to the hospital following the incident. (R1) returned to the facility on (local) hospice on January 29, 2026. (R1) passed away on January 21, 2026."	A2050		

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 02/05/2026

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
A2050	Continued From page 2 On 2/4/26 at 12:30 pm, E1 ED stated it was oversight on her part that she forgot to send the initial report to the State Agency. E1 stated she sent the initial and final on 2/2/26.	A2050		