

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ASL510373	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/18/2025
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NAME OF PROVIDER OR SUPPLIER TRENTON VILLAGE, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 980 E BROADWAY TRENTON, IL 62293
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A 000	Initial Comment Complaint Investigation #2548450/IL197322 Complaint Investigation #2548701/IL197457 Violations Cited: 295.3000 a) 295.4060 a) h) 6) i) 2) B) i) REPEAT 295.5000 a) c) e) f) 2) h) 1) 295.6000 a) 1) 2)	A 000		
A3000	Section 295.3000 Personnel Requirmts, Qualifns, and Trng This Regulation is not met as evidenced by: Type 2 Violation Section 295.3000 Personnel Requirements, Qualifications and Training a) The establishment shall have staff sufficient in number with qualifications, adequate skills, education and experience to meet the 24 hour scheduled and unscheduled needs of residents and who participate in ongoing training to serve the resident population. (Section 35(a)(3) of the Act) Based on interview and record review, the Establishment failed to ensure that staff were trained on policies and procedures related to medications being secure and the use of social media. This failure has the substantial probability of physical harm as well as psychosocial harm to the residents residing at the Establishment. The Establishment's resident roster, provided to surveyor upon entrance documents 57 residents residing in the building.	A3000		

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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A3000	<p>Continued From page 1</p> <p>Findings include:</p> <p>1) The Establishment's Policy, undated, titled Medication Pass documents, 1. Each resident with Medication Supervision has their medication stored in a locked box in their room. Each box is labeled with the resident's name. 4. The boxes are locked with a code that only appropriate staff can access.</p> <p>R4's Service Plan, dated 5/2/2025 documents that she receives her medication with supervision.</p> <p>R4's Medication Orders, dated 8/27/25 documents that she is to receive Enalapril tab 10 MG twice a day and Vitamin D3 25MCG/1000IU.</p> <p>R4's Occurrence Report, dated 8/30/2025 at 11:00 PM documents, medication error completed by E9/Personal Care Assistant, "Staff gave bedtime medication originally at 8:00 PM, staff did not have lock box in lock setting. Resident opened looking for her medication when she called staff for assist, she had taken her Enalapril 10 MG and Vitamin D3 for the next night. (Enalapril is a prescription medication that is used to treat high blood pressure and heart failure).</p> <p>On 9/9/2025 at 11:15 AM, E1/Executive Director and E2/Assistant Director confirmed that on 8/30/2025 at 11:00 PM, R4 got into her medication box that had not been securely locked in place by E9/Personal Care Assistant and took an extra dose of her Enalpril and Vitamin D3.</p> <p>2) The Establishment's Policy on Social Media, dated 1/1/2025 documents, "4. Accessing Blogs/Social Networking Media on the Facility's time and equipment. The Facility's</p>	A3000		

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A3000	<p>Continued From page 2</p> <p>Communications Systems Policy governs all use of the Facility's equipment extends to personal blogs and communications through social networking sites. You are not to use the Facility's equipment or time to create or update your blog or social networking site."</p> <p>Review of the Establishments final report of the "SnapChat" allegations, dated 9/15/2025 documents that there were staff that did use the Social Media site while at work. Statement from E8/Personal Care Assistant confirmed that she posted a few people on a private story of herself, not naming any names. E8's "SnapChat" to friends stated "working with someone who applied toothpaste instead of pericare to someone's bottom while supposed to be a CNA." E10/Activity Department's statement documents, that she received the Snapchat from E8.</p> <p>On 9/17/2025 at 12:30 PM E1/Executive Director confirmed that staff had been utilizing the social media site while working against their policy.</p>	A3000		
A4060	<p>Seciton 295.4060 Alzheimer's and Demential Programs</p> <p>This Regulation is not met as evidenced by: TYPE 2 VIOLATION</p> <p>Section 295.4060 Alzheimer's and Dementia Programs</p> <p>a) In addition to this Section, Alzheimer and dementia programs shall comply with all of the other provisions of the Act. (Section 150(a) of the Act)</p>	A4060		

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A4060	<p>Continued From page 3</p> <p>h) An establishment that offers to provide a special program for persons with Alzheimer's disease and related disorders shall:</p> <p>6) Provide an appropriate number of staff for its resident population. The establishment shall provide staff sufficient in number, with qualifications, adequate skills, education, and experience to meet the 24-hour scheduled and unscheduled needs of the residents and who participate in ongoing training, to serve the resident population.</p> <p>i) Training requirements for individuals working in a special program:</p> <p>2) Staff training</p> <p>B) Direct care staff must receive 16 hours of on-the-job supervision and training within the first 16 hours of employment following orientation. Training must cover:</p> <p>i) encouraging independence in and providing assistance with the activities of daily living.</p> <p>Based on observation, interview and record review, the Establishment failed to ensure staff were adequately trained in providing assistance with activities of daily living which includes applying barrier creams for residents with a history of excoriation due to urinary incontinence. This failure resulted in (E3) applying toothpaste to (R7) excoriation causing pain. This failure has the high probability of causing harm to all the residents residing on the Memory Care Unit of the Establishment.</p>	A4060		

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A4060	<p>Continued From page 4</p> <p>Findings Include:</p> <p>The Establishment's resident roster provided to surveyor documents 15 residents reside on the Memory Care Unit including R7.</p> <p>The Establishment's Alzheimer's Disease Special Care Disclosure, dated 4/10/22 documents, "In addition to the treatment plan for a resident, the Dementia Special Care Unit will also address the emotional and mental support needed for the resident's loved ones. the Dementia Special Care Unit is unique to be able to offer these services because it will encompass highly skilled staff that will be trained to meet the needs of the residents and their loved ones. The direct care staff will receive proper training on Alzheimer's disease and related disorders. the training will cover various topics of the disease process such as understanding behaviors, proper communication with residents, and the physical effects. This high quality training will help the staff be successful caregivers for residents living with Alzheimer's disease and other related disorders."</p> <p>E3's personnel file documents a hire date of 8/21/25. E3's file documents orientation is still in process with all required training up to date.</p> <p>R7's Medical Record, dated 9/4/25, documents the Diagnosis of Dementia without Behavioral Disturbances.</p> <p>R7's Service Plan, dated 9/1/25 documents that she is high risk for skin breakdown due to frequent incontinence, requires assistance to be assisted to the toilet, always assist with peri care and if the peri area looks red, use cream as prn (as needed) and report to the Nurse.</p>	A4060		

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A4060	<p>Continued From page 5</p> <p>R7's Occurrence Report, dated 9/8/2025 at 5:00 PM documents that during toileting assistance by E3/PCA (Personal Care Assistant), R7 had a rash noted to her bottom and E3/PCA applied sensodyne toothpaste to the rash instead of the barrier cream Calmoseptine.</p> <p>On 9/10/2025 at 9:45 AM, E1/Executive Director confirmed that E3/Personal Care Assistant applied toothpaste to (R7) instead of the barrier cream used for incontinent episodes.</p> <p>On 9/17/2025 at 11:00 AM, during interview with R7 in her apartment on the Memory Care Unit with witness E11/LPN, R7, Lucid, Alert and Oriented to her surroundings was able to recall the incident on 9/8/2025 stating, " She/E3 put toothpaste on by butt, I started screaming it hurt so bad."</p> <p>On 9/17/2025 at 11:26 AM, Z3/R7's POA stated, "I came in to give R7 a shower around 5:30 PM, R7 told me she had already had a shower, then E3/PCA came in and told me what had happened. I checked R7, her buttocks was red with irritation noted. R7 told me that it had really burned when the toothpaste was applied. I gave her another shower and put some Vaseline on it to help soothe it."</p> <p>On 9/17/2025 at 11:05 AM, surveyor observed the tube of toothpaste and the tube of Calmoseptine skin barrier cream. The toothpaste is clearly marked Sensitive Extra Whitening Fluoride toothpaste in a small white tube. The Calmoseptine skin barrier cream is 2-3 times bigger, white with large green label that clearly states protects, soothes and helps healing.</p>	A4060		

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A5000	Continued From page 6	A5000		
A5000	<p>Section 295.5000 Medication Reminders, Supervision of Self Med</p> <p>This Regulation is not met as evidenced by: REPEAT TYPE 2 VIOLATION</p> <p>Section 295.5000 Medication Reminders, Supervision of Self-Medication, Medication Administration and Storage</p> <p>a) An establishment may provide medication reminders, supervision of self-administered medication, and medication administration as an optional service.</p> <p>c) Supervision of self-administered medication means assisting the resident with self-administered medication using any combination of the following. Supervision of self-administered medication by unlicensed personnel shall be under the direction of a licensed health care professional.</p> <p>e) Medication stored by a resident in the resident's unit shall be stored and controlled as stated in the resident's service plan and shall be inaccessible to other residents.</p> <p>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:</p> <p style="padding-left: 40px;">2) Storing and controlling medication;</p> <p>h) Any medication stored by the establishment</p>	A5000		

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A5000	<p>Continued From page 7</p> <p>shall meet the following requirements:</p> <p>1) Medication shall be stored in a locked container, cabinet, or area that is inaccessible to residents.</p> <p>Based on interview and record review the Establishment failed to ensure medications were administered as ordered by the Physician, without error and to securely store medications in a locked box. This failure resulted in R4 entering the unlocked medication box and taking a double dose of a blood pressure medication. This failure has the substantial probability of harm to the residents residing in the Establishment.</p> <p>Findings include:</p> <p>The Establishment's resident roster, provided to surveyor upon entrance documents 57 residents residing in the building.</p> <p>The Establishment's Policy, undated, titled Medication Pass documents, 1. Each resident with Medication Supervision has their medication stored in a locked box in their room. Each box is labeled with the resident's name. 4. The boxes are locked with a code that only appropriate staff can access.</p> <p>R4's Service Plan, dated 5/2/2025 documents that she receives her medication with supervision.</p> <p>R4's Medication Orders, dated 8/27/25 documents that she is to receive Enalapril tab 10 MG twice a day and Vitamin D3 25MCG/1000IU.</p> <p>R4's Occurrence Report, dated 8/30/2025 at 11:00 PM documents, medication error completed by E9/Personal Care Assistant, "Staff</p>	A5000		

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A5000	Continued From page 8 gave bedtime medication originally at 8:00 PM, staff did not have lock box in lock setting. resident opened looking for her medication when she called staff for assist,she had taken her Enalapril 10 MG and Vitamin D3 for the next night. (Enalapril is a prescription medication that is used to treat high blood pressure and heart failure) On 9/9/2025 at 11:15 AM, E1/Executive Director and E2/Assistant Director confirmed that on 8/30/2025 at 11:00 PM, R4 got into her medication box that had not been securely locked in place by E9/Personal Care Assistant and took an extra dose of her Enalapril and Vitamin D3.	A5000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: VIOLATION TYPE 2 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: 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; 2) The right to respect for bodily privacy and	A6000		

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A6000	<p>Continued From page 9</p> <p>dignity at all times, especially during care and treatment;</p> <p>Based on observation, interview and record review, the Establishment failed to ensure residents were treated with dignity and respect during care when staff (E3) applied toothpaste to (R7) excoriated buttocks after being assisted with toileting. This failure caused pain to R7.</p> <p>Findings include:</p> <p>R7's Medical Record, dated 9/4/25, documents the Diagnosis of Dementia without Behavioral Disturbances.</p> <p>R7's Service Plan, dated 9/1/25 documents that she is high risk for skin breakdown due to frequent incontinence, requires assistance to be assisted to the toilet, always assist with peri care and if the peri area looks red, use cream as prn (as needed) and report to the Nurse.</p> <p>R7's Occurrence Report, dated 9/8/2025 at 5:00 PM documents that during toileting assistance by E3/PCA (Personal Care Assistant), R7 had a rash noted to her bottom and E3/PCA applied sensodyne toothpaste to the rash instead of the barrier cream Calmoseptine.</p> <p>On 9/10/2025 at 9:45 AM, E1/Executive Director confirmed that E3/Personal Care Assistant applied toothpaste to (R7) instead of the barrier cream used for incontinent episodes.</p> <p>On 9/17/2025 at 11:00 AM, during interview with R7 in her apartment on the Memory Care Unit with witness E11/LPN, R7, Lucid, Alert and Oriented to her surroundings was able to recall the incident on 9/8/2025 stating, " She/E3 put</p>	A6000		

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A6000	<p>Continued From page 10</p> <p>toothpaste on by butt, I started screaming it hurt so bad."</p> <p>On 9/17/2025 at 11:26 AM, Z3/R7's POA stated, "I came in to give R7 a shower around 5:30 PM, R7 told me she had already had a shower, then E3/PCA came in and told me what had happened. I checked R7, her buttocks was red with irritation noted. R7 told me that it had really burned when the toothpaste was applied. I gave her another shower and put some Vaseline on it to help soothe it."</p> <p>On 9/17/2025 at 11:05 AM, surveyor observed the tube of toothpaste and the tube of Calmoseptine skin barrier cream. The toothpaste is clearly marked Sensitive Extra Whitening Fluoride toothpaste in a small white tube. The Calmoseptine skin barrier cream is 2-3 times bigger, white with large green label that clearly states protects, soothes and helps healing.</p>	A6000		