STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145781	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Generations at Applewood	21020 Kostner Avenue Matteson, IL 60443

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40920 Based on observation, interview, and record review, the facility failed to provide treatment and services to prevent development of a pressure ulcer; failed to promote wound healing and prevent infection for a dependent resident who was assessed as being at risk for pressure ulcer; and failed to perform weekly skin assessments as ordered. These failures applied to one (R1) of three residents reviewed for pressure ulcers and resulted in R1 developing a stage 4 facility acquired pressure ulcer to her sacrum, which required hospitalization for treatment of infection and surgical wound debridement. Findings include: R1 is a [AGE] year-old female who was admitted to the facility on [DATE]. Her past medical history includes, but not limited to Local infection of the skin and subcutaneous tissue, dysphagia, peripheral vascular disease, pressure ulcer of sacral region stage 3, pressure ulcer of right elbow stage 4, venous insufficiency, hypothyroidism, hyperlipidemia, gastro esophageal reflux disease without esophagitis, chronic kidney disease stage 3, etc. Pressure ulcer list provided by the facility documented that R1 has 3 facility acquired pressure ulcers, stage 3 to the right elbow, stage 4 to the left leg and stage 4 to the sacrum. Wound note dated 11/5/2024 documented the following: stage 4 pressure wound sacrum full thickness, duration >2 days, wound size 8.0 x 15.5 x not measurable c. Depth is unmeasurable due to presence of nonviable tissue and necrosis. Hospital record dated 11/11/2024 documented in part, [AGE] year-old female presented from nursing home with pressure ulcer on the right elbow and worsening of sacral decubitus ulcer with foul smell draining pus. Same hospital records documented empiric treatment with IV (intravenous) Vancomycin and IV Zosyn, general surgery consulted, planning for surgical debridement. The record also documented that based on clinical assessment at admission, patient will require more than 2 medically necessary midnights of in-hospital care because of sacral decubitus ulcer infection. Infectious disease section of the hospital record documented that R1 will be de-escalated to Unasyn 3 grams every 8 hours to be continued at the nursing home for a total of 6 weeks. Minimum data set (MDS) assessment dated [DATE] section C (cognitive patterns) scored R1 as a 7 for brief interview for mental status (BIMS). Section GG (functional status) of the same assessment documented that R1 is dependent on staff for all activities of daily living (ADLS). Section H (bowel and bladder) documented that R1 is always incontinent of bowel and bladder. (continued on next page)

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R1 has an order for weekly skin checks dated 8/30/2024, and there is no documentation of any skin checks in her medical record. 1/13/2025 at 9:40AM, R1 was observed in her bed, awake and alert and stated that she is doing okay. R1 said that she has not been changed today, she was last changed yesterday and feels like she is wet. R1 also said that no one has changed her wound dressing yet, she does not know who is her assigned certified nurse assistant (C.N.A) for today. At 9:46AM, V4 (C.N.A) was observed in the hallway and stated that she is assigned to R1, she has not changed R1 or her roommate yet, she was going to get them next after she finished with the resident she is helping right now. 1/13/2025 at 10:10AM, V4 (C.N.A) and V5 (restorative) were observed coming out of R1's room, holding a bag of dirty linen, V4 said that they just changed resident, her roommate is okay and does not need to be changed. Surveyor asked to see resident's dirty incontinence brief and noted a large area of reddish stain that saturated the brief. V4 stated that R1 was not wet, the stain is from her wounds. Surveyor asked to see resident's wounds and noted a large area of deep wound on resident's sacrum that looks red, with lots of drainage. V4 and V5 applied a clean incontinence brief on R1 with no dressing covering the wound and said that they will inform wound care nurse that resident's wound does not have any cover. 1/13/2025 at 1:05PM, R1 was observed still lying on her back and stated that no one has come to turn her or put a dressing on her wound. 1/13/2025 at 2:00PM, Observed wound care for R1 with V3 (DON) and V11 (Wound Tech). When V3 removed resident's incontinence brief, it was soaked with wound drainage and there was no dressing covering resident's wounds. Surveyor presented this observation to V3 and she said that she was not aware that R1 did not have any dressing to her wounds, no one informed her. She added that the wound should not be left without dressing because it will be losing hemostasis. 1/15/2025 at 11:58AM, V13 (LPN-Licensed Practical Nurse/Wound Care) said that she is familiar with R1 and has been treating her wounds since she was admitted to the facility. V13 said that she first became aware of resident's sacral wound on 11/4/2024, the wound team was just treating residents leg wound that was present on admission and were not aware of anything going on in resident's sacrum. V13 added that the wound care team did not do another skin assessment apart from the one done upon admission. As for the resident's order for weekly skin assessment, the floor nurses are supposed to do that in conjunction with the C.N.A's during ADL care and notify wound care of any skin alterations. V13 added that the facility dropped the ball this time, there was a gap in communication, resident's wound could have been identified earlier. Facility pressure injury prevention protocol (undated) stated in part: 1. Residents will be assessed to determine their risk factor(s) for pressure injury development, upon admission; weekly x 4 weeks following admission/readmission and at least quarterly thereafter. 4. Residents will have their skin checked and documented utilizing the Treatment Administration Record. This skin check will be performed at a minimum of weekly. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Skin Assessment Policy and Procedure (undated) documented the following: Intact, healthy skin is the body's first line of defense. It is the policy of this facility to monitor the skin integrity for signs of injury and irritation. In addition to ongoing assessment of the skin, the facility will implement measures to protect the resident's skin integrity and to prevent skin breakdown. Upon admission to the facility the following will be assessed: (1) Risk for developing pressure injuries using valid assessment of pressure injury risk; (2) General skin condition; (3) Current injuries. Under procedures, the policy documented in part: All resident's, regardless of risk, will have a documented weekly review of skin condition.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40920 Based on observation, interview, and record review, the facility failed to ensure that staff use proper personal protective equipment (PPE) when caring for residents on enhanced barrier precaution, failed to ensure that respiratory equipment mask was properly contained, and failed to ensure that staff follow proper hand hygiene practices during wound care for a resident. These failures affected two (R1, R2) of two residents reviewed for infection control. Findings include: 1. R1 is a [AGE] year-old female who was admitted to the facility on [DATE] past medical history includes, but not limited to Local infection of the skin and subcutaneous tissue, dysphagia, peripheral vascular disease, pressure ulcer of sacral region stage 3, pressure ulcer of right elbow stage 4, venous insufficiency, hypothyroidism, hyperlipidemia, gastroesophageal reflux disease without esophagitis, chronic kidney disease stage 3, etc. 1/13/2025 at 10:10AM, V4 (CNA-Certified Nurses Assistant) and V5 (Restorative Aide) were observed coming out of R1's room, holding a bag of dirty linen. V4 said that they just changed resident (R1). V4 and V5 were not wearing any personal protective equipment while changing R1, resident has an enhanced barrier precaution sign on her door. 1/13/2025 at 2:00PM, observed wound care for R1 with V3 (LPN-Licensed Practical Nurse) and V11 (Wound Tech). V3 donned gloves and removed the dressing on R1's right ankle, observed a large area of open wound that appeared to have exposed the bone. V3 cleaned the wound, changed her gloves, and applied treatment and dressing, she did the same for resident's left ankle, continues to change gloves without performing any type of hand hygiene in between. V3 completed the whole wound care without washing her hands or using a hand sanitizer. When she was done, she left the room and returned to her cart without washing her hands. Neither V3 nor V11 wore any gown during the wound care. 1/13/2025 at 3:27PM, surveyor presented her observations to V3 (LPN), and she said, I did not even see the enhanced barrier precaution sign on the door, we would normally wear a gown when providing wound care for residents on this type of isolation. Regarding hand hygiene, V3 said that she changed her gloves when going from dirty to clean, she did not know that she must wash her hands or use an alcohol hand rub according to the training she got from her previous job. V3 added that hand hygiene should be performed before providing care and after. 1/13/2024 at 3:27PM, V2 (DON-Director of Nursing) said that the expectation for hand hygiene is that staff wash their hands before providing care, during care and after the care. Hand hygiene should be performed after removing gloves, staff can either wash their hands or use an alcohol-based hand sanitizer. For residents on enhanced barrier precaution, V2 said that staff are supposed to wear an isolation gown when providing care, she noticed that V3 and V11 were not wearing any gown during the wound dressing change, she wanted to say something, but not sure if she should in the presence of the surveyor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. R2 is a [AGE] year-old-male who has resided at the facility since 5/28/2024, past medical history includes Acute and chronic respiratory failure with hypoxia, anemia, other seizures, hemiplegia unspecified affecting SLP right dominant side, metabolic encephalopathy, essential primary hypertension, unspecified arterial fibrillation, dysphasia, aphasia, etc. 1/13/2025 at 9:55AM, R2 was observed in his room in bed, awake and alert but could not respond to questions. G-tube (Gastrostomy Tube) noted at bedside and infusing via gravity, resident with trach and connected to a vent via trach collar, ambu bag and suctioning equipment also at bedside. 1/13/2025 at 10:10AM, observed incontinence care for R2 with V4 (CNA) and V5 (Restorative Aide), noted resident's incontinence brief saturated with urine and bowel movement and brownish in color. Surveyor asked staff the last time resident was changed, and they did not know, V5 said that she is not sure, she is just over here to help. V4 and V5 donned gloves before the procedure but were not wearing any gown. R1 and R2 noted to have enhanced barrier precaution sign on their doors, that read in part, employees clean their hands, including before entering and when leaving the room. Providers and staff must also wear gloves and gown for the following high contact-resident care activities: dressing, bathing/showering, transferring, providing hygiene, wound care-any skin opening requiring dressing, etc. Hand hygiene policy (undated) states in part, hand hygiene (hand washing or the use of an alcohol based and rub) is regarded by this organization as is the single most important means of preventing the spread of infection. Hand hygiene must be under the following conditions: a. before and after assisting residents with personal care. J. before and after changing dressing. T. after removing gloves or aprons. 3. The use of gloves does not replace hand washing/hand hygiene. Enhanced barrier precaution policy undated starts in part: Objective: To prevent transmission of novel or targeted multidrug resistant organisms through 1. Enhanced Barrier Precautions (EBP) refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. 2. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. implementation of enhanced barrier precautions. 3. EBP are applied (when Contact Precautions do not otherwise apply) to residents with any of the following: b. Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO.