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	02/20/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40102 Based on interview and record review, the facility failed to safely position a resident in the bed while providing incontinence care and prevent a resident from rolling out of the bed onto the floor. This affected one of three residents (R6) reviewed for safety during care. Findings include: R6 is an [AGE] year old with the following diagnosis: heart failure, end stage renal disease with dependence on dialysis, weakness, lack of coordination, and muscle wasting and atrophy at multiple sites. A Nursing note dated 12/2/24 documents R6 fell from bed while the CNA (Certified Nurses Assistant) was attending to R6's needs. Vitals signs were stable but 911 was called due to neck pain. The Fall Report dated 12/2/24 documents the CNA (V13) reported R6 rolled out of bed while V13 was providing care. V13 stated V13 turned to grab a new pad and R6 yelled R6 lost R6's grip and fell . R6 stated R6 overestimated the turn and lost R6's grip and balance. No injuries were noted. A conclusion or root cause of the fall is not documented. The Hospital Records dated 12/2/24 documents R6 presented to the emergency department post fall at the nursing home. R6 fell from the bed. A CT scan of the head and neck were negative and x-rays of the chest and pelvis were also negative. On 2/18/25 at 1:26PM, V9 (R6's Family Member) stated R6 fell out of bed while V13 (CNA) was changing R6. V9 reported R6 was weak and unable to maintain the side lying position while being changed causing R6 to fall out of bed. On 2/18/25 at 3:00PM, V10 (Nurse) stated V13 called V10 into the room because R6 rolled out of bed onto the floor. V10 reported V13 told V10 that R6 lost R6's balance and fell out of the bed. V10 stated there was only one CNA changing R6 and R6 was very weak. V10 reported R6 was a larger person and could not move around the bed without assistance from staff. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/18/25 at 3:12PM, V11 (Restorative Nurse) stated R6 needed partial/moderate assistance with turning and repositioning. V11 reported R6 was in the restorative bed mobility program to help R6 become stronger at rolling side to side in bed and also received physical therapy. V11 stated a CNA should log roll a resident to the side then reposition them to the middle of the bed when providing incontinence care. V11 reported moving the resident to the middle of the bed is important because if they are left too close to the side after turning then a resident can fall out of the bed easier. On 2/18/25 at 3:30PM, V12 (Director of Therapy) stated R6 was weak and very deconditioned in both bilateral upper and lower extremities. V12 reported R6 was weak in the core which causes balancing issues. V12 stated R6 needed partial/moderate assistance with turning in bed indicating R6 needed a staff member to perform 25-50% of the task. V12 said, She couldn't even hold the utensil to eat some days because she was so weak. V12 reported R6 was at risk for falls due to how weak R6 was. V12 stated if R6 was not properly positioned in bed then R6 had a greater chance of rolling out of bed due to being weak. On 2/18/25 at 4:11PM, V8 (DON-Director of Nursing) stated R6 rolled out of bed while V13 turned around to grab something. V8 reported R6 was working with physical therapy but V8 was unaware of what R6 could and couldn't do without assistance. On 2/19/25 at 11:34AM, V13 (CNA) stated V13 was providing incontinence care to R6 when R6 fell out of bed. V13 reported V13 assisted R6 with rolling to the left side and cleaned R6. V13 stated V13 turned around to grab a clean pad and took eyes off R6 and when V13 was turning back around, R6 was falling off the bed. V13 stated the bed was in a higher position due to incontinence care being provided. V13 reported due to R6's size, V13 was unable to stop the fall from happening. V13 stated R6 needed assistance with turning over in bed due to being weak. V13 reported R6 was turned over onto the left side near the edge of the bed because V13 could not pull R6 back to the middle of the bed. V13 stated V13 could not pull R6 to the middle of the bed because R6 was too large to pull alone. V13 said, I shouldn't have turned around, but I didn't think she was going to roll out of the bed. V13 reported R6 is very weak to hold R6's self up on the side. The Lift/Transfer Evaluation dated 11/12/24 documents R6 needs partial assistance with repositioning in bed. The Fall Risk Evaluation dated 11/12/24 documents R6 is at risk for falls. The assessment is not completed with a score indicating why R6 would be a fall risk. The Physical Therapy Evaluation dated 11/13/24 documents R6 was referred to therapy services due to declining balance, strength, bed mobility, transfer activities, and ambulation. R6 is a fall risk. Clinical Impressions: R6 presents with balance deficits, decreased functional capacity, decreased safety awareness, and strength impairments. The Restorative Nursing Screener dated 11/26/24 documents R6 needs partial/moderate assistance with rolling left and right. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Physical Therapy Encounter note dated 11/30/24 documents R6 worked on balance exercises by sitting on the edge of the bed, postural support/control, range of motion, safety awareness, and strength to bilateral lower extremities. R6 required 25% verbal instructions due to compromised balance, functional activity tolerance, safety awareness, range of motion, postural support/control, and strength. The Care Plan dated 11/12/24 documents R6 is at risk for falls. The Care Plan dated 12/2/24 documents R6 had an actual fall with no injury due to poor balance. The Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status score as 14 (no cognitive impairment). Section GG of the MDS documents R6 needs partial/moderate assistance with rolling left and right. Partial/moderate assistance mean helper does less than half the effort.