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	03/28/2025

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 - Minimal harm or potential for 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** 40102 Based on interview and record review, the facility failed to implement pressure sore prevention interventions, including the use of a low air loss mattress, and failed to perform dressing changes to the sacral wound and conduct daily skin assessments as ordered. The facility failed to document when and under what condition the sacral wound was initially identified. This failure affects one of the three residents (R3) reviewed for wound care and prevention interventions. Findings include: R3 is a [AGE] year old with the following diagnosis: stage 3 pressure ulcer of the right hip, dysphagia, adult failure to thrive, heart failure, and chronic obstructive pulmonary disease. An Initial Wound Evaluation and Management Summary dated 2/18/25 documents R3 presented with wounds to the right hip (stage 3) and right distal medial foot (deep tissue injury). Plan is to offload wound and reposition per facility protocol. There is no documentation R3 had a sacral wound upon initial evaluation. A Nurse Practitioner note dated 2/20/25 documents R3's family member requested R3 be sent out to the hospital for G tube placement. R3 has been on hospice since 12/5. A phone call was made with staff, the hospice company and R3's family, and it was decided to revoke hospice. R3 was sent out to the hospital per families request for Gastrostomy tube placement. R3 has failure to thrive in adult. A Nursing note dated 2/27/25 documents R3 returned to the facility with a diagnosis of failure to thrive. R3 had a dressing to the right hip and a Deep Tissue Injury (DTI) to the left heel. A Skin/Wound note dated 2/28/25 documents R3 returned to the facility yesterday on hospice. Upon skin observation, R3 was noted to have a right hip wound and a distal medial foot wound. No redness or swelling was noted to the sacrum, heels, or elbows. A Wound Care note dated 3/4/25 documents R3 was supposed to be seen by wound care during wound care rounds. R3 kept yelling to be left alone. R3 was educated on risk and benefits of refusing wound care treatments R3 verbalized understanding and stated R3 was too tired to continue. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/26/25 at 1:09PM, V1 (Wound Care Coordinator) stated R3 originally had a low air loss mattress that was provided by hospice. V1 reported R3's family member revoked hospice the day R3 was sent out to the hospital but V1 was not made aware of this. V1 stated when R3 returned form the hospital R3 had a right hip wound and a deep tissue injury to the right heel. V1 was not able to answer when the sacral wound was first identified or in what condition the wound was in when it was first identified. V1 denied there was any documentation when the wound was first identified. V1 stated since R3 was removed from hospice, the hospice company took their air mattress back. V1 reported V1 was unaware for about a week that R1 returned to the facility off hospice. V1 stated an order was put in to treat the sacral wound on 3/4/25 but V1 was unable to remember how the wound was identified. V1 reported skin assessments need to be completed daily on residents with wounds and documented in the Treatment Administration Record (TAR). V1 stated dressing changes should also be performed as ordered or the wound could get worse. V1 reported R3 is at high risk for developing pressure ulcers due to lack of nutrition, incontinence, having wounds in the past, and immobility. V1 stated if there is no documentation in the TAR then it is assumed it was no done. On 3/27/25 at 1:45PM, V14 (Wound Care Technician) stated R3 currently has a sacral wound. V14 denied seeing R3's sacral area on 3/4/25 during wound rounds because R3 refused to be cleaned or have the dressing changed at the time. V14 reported R3 was on hospice but when R3 returned from the hospital, R3 was no longer on hospice. V14 stated V14 does not know when or who found the sacral wound. V14 reported when a new skin alteration is noted then staff should tell the wound care team the same day. V14 was unable to remember if R3 was on a low air loss mattress on 3/4/25 but stated R3 is on an air loss mattress now. V14 stated the CNAs are responsible for doing skin checks once a week. When V14 was asked if skin assessment should be performed daily, V14 replied, No. On 3/28/25 at 1:41PM, V15 (Wound Care Physician) stated R3 was on hospice but was taken off. V15 was unable to provide the date R3 was removed from hospice. V15 reported V15 was unable to remember and unable to look up when V15 was first notified of the sacral wound and what stage the wound was in when it was first identified. V15 stated based on the first order placed of xeroform the wound to the sacrum was not advanced and could have only been some kind of opening to the skin. V15 reported R3 would be considered high risk for developing wounds due to age, refusing treatments, being incontinent, and poor oral intake. V15 stated V15 should be notified immediately of a new skin alteration so orders can be entered and treatments can begin. V15 said, If you don't do treatments or assess the skin thoroughly, then wounds can deteriorate very quickly. V15 reported it is very likely for a sacral wound to deteriorate from a small opening to a stage three within a week. V15 stated R3 is a resident that would benefit from a low air loss mattress because R3 cannot move around as much and these mattresses help prevent further wounds by relieving pressure. V15 was not able to answer when the air mattress was ordered but confirmed the nurse is responsible for getting the interventions in place that are discussed during rounds. V15 reported the interventions to prevent further wounds/wounds from deteriorating should be put in place within the same day if possible. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/28/25 at 3:22PM, V16 (DON) stated R3 was on hospice before going to the hospital and hospice provided the air mattress at that time. V16 reported R3 was removed from hospice care upon returning to the facility. V16 stated the wound care team assessed R3 during rounds and determined R3 needed an air mattress at that time. V16 reported the air mattress was ordered and delivered to the facility within one day. V16 was unaware of how many days R3 was in the facility before the air mattress was ordered. V16 stated once a new skin alteration is noticed then wound care and a physician must be notified, a progress note must document the wound, and treatment orders should be put in place to care for the wound. V16 reported a new skin alteration should always be documented because that way staff can tell when it was developed and who was notified. V16 stated V16 was unaware if skin assessment should be completed daily or twice weekly for residents with wounds and V16 would need to reference the policy for a correct response. V16 reported skin assessment should always be documented even when no new skin alterations are found. V16 stated wound interventions should be put in place as soon as possible once the resident is determined to be at risk to prevent wounds. There is no documentation that a wound physician saw R3 again until 3/11/25 after the visit on 2/28/25. The Wound Care Physician note dated 3/11/25 documents there is new documentation of a stage three pressure wound to the sacrum that measures 2.1 cm x 1.6 cm x 0.1 cm. It is documented that the duration of the wound is greater than five days. There's no documentation on when the wound was first noted or what stage the wound was when it was first identified. Continued recommendations for offloading and repositioning per facility protocol. The Wound Physician note dated 3/21/25 documents the sacral wound has now advanced to a stage four pressure ulcer and measures 4.8 cm x 3.0 cm x 1.7 cm. This wound is documented as exacerbated due to infection. The wound has a large black wet necrotic area with a foul odor. The Physician Order Sheet documents an order for the sacral wound was originally placed on 3/5/25 by V1 that received a verbal ordered from V15. The Treatment Administration Record (TAR) dated 02/2025 documents R3 was receiving treatment for a right distal medial foot wound and a right hip wound. There is no order for a sacral wound dressing. There is also an order that R3 should receive daily skin checks. Skin checks were not completed for five days as there is no documentation on the TAR that the skin checks were completed. The TAR from 03/2025 documents an order for a sacral wound to be cleansed with normal saline and xeroform with a dry dressing to be changed daily was placed on 3/4/25. Per the TAR, there was no documentation of this dressing change was completed on 3/5/25, 3/10/25, and 3/14/25 as ordered. A new order was placed on 3/15/25 to cleanse the sacral wound with normal saline, pat dry and apply thera honey then apply calcium alginate and cover with a dry dressing daily. There is no documentation of this dressing change being completed on 3/18/25, 3/22/25, 3/23/25, 3/24/25, and 3/25/25 as ordered. There's also an order for skin checks to be completed daily. There are only three skin assessments completed from 3/4/25 through 3/25/25. Skin assessments were not completed on R3 a total of 18 times per documentation. An email dated 3/3/25 documents central supply ordered a low air loss mattress for R3 from the purchasing agent at the facility. The low air loss mattress documents the delivery slip as the mattress was delivered on 3/4/25. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Braden Scale for Predicting Pressure Ulcer Sore Risk documents a score of 11 indicating R3 is at high risk for developing pressure ulcers due to being very moist, chairfast, very limited mobility, very limited sensory perception, has inadequate nutrition, and has a problem with friction and shearing. The Care plan dated 2/14/25 documents R3 has a potential for impaired skin integrity as evidenced by Braden scale indicating or is high risk for pressure ulcers. An intervention documented on 2/14/25 indicates a pressure reducing mattress should be used on the bed and to monitor skin conditions and report any skin alterations. The Care Plan revised 3/14/25 on documents R3 has an actual skin impairment of the right distal medial foot that is a deep tissue injury, a pressure wound to the right hip, and a pressure ulcer to the sacrum. An intervention documented on 2/28/25 documents R3 needs a pressure relieving/reducing mattress and heel boots to protect the skin while in bed. The Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status score as a six (severe cognitive impairment). Section GG of the MDS documents R3 needs substantial/maximal assist with bed mobility. Section M of the MDS documents R3 is at risk for developing pressure ulcers. At the time of the assessment, it is documented R3 did not have any unhealed pressure ulcers or any other injuries present. A policy that was sent via email by the facility that is untitled and undated documents, Objective: 1. Residents will be assessed to determine their risk factor(s) for pressure ulcer development Procedure: 1. Residents will be assessed to determine their risk factor(s) for pressure ulcer development, upon admission and at least quarterly thereafter. 2. All beds in the facility will have pressure reducing mattresses unless pressure relieving mattresses are required according to the resident's needs . 4. Interventions necessary to maintain skin integrity or to promote healing will be incorporated into the plan of care based on each resident's individual needs and risks, which may include: A. Daily skin checks conducted by either the CNA or Licensed Nurse to ensure early identification of potential problem areas. B. Plan of Care to address mobility status and ability to reposition self. C. Use of Pressure Reducing Devices, such as pressure reducing mattresses, mattress overlays, w/c cushioning devices, if needed . 6. Residents will have their skin checked and documented. This skin check will be performed at a minimum of weekly.