| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145781 | A. Building<br>B. Wing | 11/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Generations at Applewood | 21020 Kostner Avenue<br>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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>(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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Based on interviews and record reviews, the facility failed to follow its abuse prevention policy and notify the State Survey Agency within the required two-hour timeframe of allegations of abuse and injury of unknown origin for six residents (R1, R2, R3, R4, R5, and R9) out of seven residents reviewed for abuse in a sample of 10.Findings include:On 9/18/25 at 3:00 PM, V1 (administrator) reviewed the date and time allegations of abuse were known and the date and time the initial reports were sent to the State Survey Agency. V1 acknowledged that the initial reports for an allegation of abuse or an injury of unknown origin must be reported immediately but not more than two hours after allegation is known.1. R1's family member on 7/21/25 at 2:00 PM reported he observed bruising on R1's arm. When R1 was questioned, R1 stated that V4 CNA (certified nurse aide) had been rough during care for R1. An abuse investigation was initiated. The initial report was not sent to the State Survey Agency until 7/21/25 at 6:06 PM.2. On 9/18/25 at 11:23 AM, V5 RN (registered nurse) stated that she recalls the conversation she had with R2's family member on 7/25/25. V5 stated that R2's family member alleged a male resident came into R2's room during the night and got in bed with R2. V5 stated that this allegation that was made would be something facility would investigate as allegation of abuse. V5 stated that V5 shared this information with the ADON (assistant director of nursing) shortly after speaking with R2's family member at 6:03 PM.R2's medical record, dated 7/25/25 at 6:03 PM, V5 RN (registered nurse) noted V5 spoke to R2's family member over the phone as R2's family member was unable to come by today (7/25). V5 relayed details of the conversation with R2. R2's family member stated that R2 told her a man came into R2's room and got into bed with R2.R2's medical record notes the incident occurred overnight 7/24 into 7/25.The initial allegation of abuse report was not sent to the State Survey Agency until 7/27/25 at 3:32 PM.3. On 7/3/25 at 9:30 AM, R3 alleged V12 CNA, overnight CNA, was rough while changing R3 and ignored R3's care preferences. An abuse investigation was initiated. The initial report was not sent to the State Survey Agency until 7/3/25 at 12:32 PM.4. On 9/18/25 at 10:45 AM, V8 (nurse) stated that V8 provided care for R4 on 8/15/25. When questioned when V8 notified V1 (administrator), V8 scrolled through her text messages on her phone and stated at 8:01am on 8/15/25 she started notifying management. V8 stated that when V8 was entering R4's room she observed a purple discoloration left lower face/chin area. V8 stated that when she assessed R4 she observed bruising in various stages on R4's face, R4's left cheek was yellowish green. V8 stated that R4 swings her right arm most of the time; R4's right side is hyperactive. V8 stated that V8 was informed that the day prior, R4 shifted herself around in bed.R4's medical record, dated 8/15/25 at 8:30 AM, V8 (nurse) noted bruising on R4's left side of face. An injury of unknown origin investigation was initiated on 8/15/25. The initial report was not sent to the State Survey Agency until 8/15/25 at 3:18 PM.5. On a facility grievance/concern form, dated 7/15/25, R5's family member reported to V1 (administrator) that a nurse allegedly gave R5 a medicine that was not ordered for R5 (melatonin). The initial report was not sent to the State Survey Agency until 7/17/25 at 3:44 PM.6. On 9/11/25 at 2:30 PM, R9 reported that a male staff member touched R9 inappropriately during care earlier in the day. The initial report was not sent to the State Survey Agency until 9/11/25 at 5:34 PM.The facility's abuse prevention policy, revised 10/2022, any allegation of abuse will be reported to the Illinois Department of Public Health immediately, but not more than two hours of the allegation of abuse. The Illinois Department of Public Health will be notified of injuries of unknown origin. Time frames for reporting and investigating abuse will be followed. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>Based on interview and record review, the facility failed to develop a person-centered care plans for four residents (R1, R2, R3, and R4) identified as at risk for abuse out of four residents reviewed for abuse in a sample of 10. Findings include:On 9/18/25 at 1:00 PM, V9 SSD (social services director) stated that social services is responsible for initiating/updating care plans related to resident behaviors, mood, and cognitive status. V9 stated that social services is not responsible for completing an abuse care plan for residents. V9 stated that V9 does not know who is responsible for initiating/updating the abuse risk care plan.On 9/18/25 at 1:23 PM, V2 DON (interim director of nursing) stated that the nurses are responsible for initiating/updating nursing related care plans, such as resident diagnosis. V2 reviewed the abuse risk assessment completed for R2. V2 stated that social service did R2's abuse risk assessment. V2 stated that care planning required that appears next to the abuse risk assessment indicates a care plan needs to be done for that resident. V2 stated that V2 thinks social services is responsible for initiating an abuse risk care plan for the resident.On 9/18/25 at 2:19 PM, V10 (social service assistant) stated that V10 and V9 complete abuse risk assessments on all residents. V10 stated that they do not initiate an abuse care plan rather document under the resident's cognition, mood, or behaviors care plan. V10 stated that they would note the allegation of abuse under the resident's behaviors care plan. 1. R1:R1's abuse risk assessment, dated 6/5/25, notes R1 is at risk for abuse/neglect evidenced by him being physically and mentally dependent on staff to make decisions and complete basic ADLs. It also notes care planning required.R1's medical record does not note an at risk for abuse care plan was initiated. 2. R2:R2's abuse risk assessment, 7/10/25, notes resident is at risk for abuse/neglect evidenced by her being physically dependent on others to complete basic ADL care. It also notes care planning required.R2's medical record does not note an at risk for abuse care plan was initiated. 3. R3:R3's abuse risk assessment, dated 8/14/25, notes R3 is at risk of abuse attributed to complications of her diagnosed chronic medical health conditions, exhibited impaired mobility status and exhibited lack of safety awareness. It also notes care planning required.R3's medical record does not note an at risk for abuse care plan was initiated. 4. R4:R4's abuse risk assessment, dated 7/14/25,notes R4 is at risk for abuse attributed to her exhibited non-verbal communication deficit, exhibited fluctuations in her cognitive functioning status and exhibited impaired mobility status. It also notes care planning required.R4's medical record does not note an at risk for abuse care plan was initiated. |