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	01/23/2026

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** Based on interview and record review, the facility failed to prevent facility acquired pressure ulcer injury to residents at risk for pressure ulcers. The facility also failed to initiate wound treatment for facility acquired pressure ulcer. These failures affect two residents (R2, R5) of three residents reviewed for pressure ulcer/skin alteration. These failures resulted in R2 developing a facility acquired pressure ulcer injury and R5 developing three facility acquired pressure ulcer injuries.Findings include:1. R2 is a [AGE] year-old female resident. admitted in the facility on 11/27/25 and discharged on 12/12/25. admitted with multiple wounds including surgical site and pressure ulcer injuries.Record reviewed and R2 was assessed to be moderate risk for pressure ulcer. Braden Scale for Predicting Pressure Ulcer Risk Evaluation dated11/27/25, score of 13 (Moderate Risk).On 12/05/25, it is documented that R2 had developed a facility acquired pressure ulcer injury. Location: Rear Left Thigh, with measurements of 4.96cm x 7.46cm x 0 (L x W x D). Wound is not staged and no other description documented with this assessment.On 1/21/26 at 11:20AM. V7 (Wound Nurse) stated that R2 is high risk for pressure ulcer injury and needs to be repositioned. R2 is High Risk due R2's mobility and R2 is dependent and total care. R2 developed a facility acquired pressure ulcer on rear left thigh assessed and documented on 12/5/25. I don't see a (stage) and other descriptions of the wound. I do not see wound treatment order also.On 1/22/26 at 9:30AM, V7 (Wound Nurse) stated that V7 does not know why the nurse who assessed the newly facility acquired pressure ulcer did not put the stage and other description of the wound. V7 stated that when assessing a wound, V7 will assess and document location site, measurement, staging and the wound bed (eschar, slough, granulation, epithelial, drainage and what type and amount). V7 stated looking at the picture taken by the nurse, V7 would stage the wound as unstageable.On 1/21/26 at 11:30AM, Treatment Administration Record and Physician Order Sheet reviewed with V7 and V7 confirmed that there is no treatment order for this sire: rear left thigh pressure ulcer. No treatment order and non-rendered from initial date for this acquired pressure ulcer wound on 12/5/25 until discharged date of 12/12/25.On 1/22/26 at 11:45AM, V19 (Wound Physician) stated that V19 can recall seeing R2 twice during R2 stay in the facility. V19 stated V19 is having problem pulling wound documents for the R2. V19 stated IT department already contacted to help V19 track down V19's wound notes for R2.V19 also stated that R2 has multiple wounds present upon admission. V19 does not recall the specific wound location site. V19 stated it is important to have a treatment for a wound as soon as it is identified. Needs treatment to take proper care of the wound. Although there is no order under physician order, it doesn't mean the resident was not getting treatment.2. R5 is a [AGE] year-old female admitted in the facility on 11/7/2024, she was sent out to the hospital on [DATE]. R5 receives dialysis at the facility every Monday, Wednesday, and Friday and requires assistance with activities of daily living. R5 is transferred to a reclining chair when she is transported for dialysis.On 1/21/2026 at 11:40 AM, V7 (Wound care coordinator), was interviewed and stated that R5 was admitted to the facility (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 - Actual harm Residents Affected - Few	with intact skin. R5's Braden Scale for predicting pressure sore risk showed a score of 17 on 6/11/2025 and a score of 17 on 9/1/2025, both of which were interpreted as at risk for pressure injury. V7 stated that R5 developed three (3) facility-acquired pressure injuries during R5's stays in the facility. R5's Skin and Wound evaluation was reviewed with V7. Wound #1 - Right heel Pressure injuryInitially identified on 11/12/2025 as a new ulcer/wound documented as a Diabetic ulcer; re-assessed on 11/19/2025 and classified as a Stage 4 pressure injuryWound measurements: 3.81 cm x 2.9 cm (surface area: 9.09 cm^2)Wound bed composition: Granulation tissue: 10%, Slough: 10%, Eschar: 80%Wound #2 - Coccyx/Sacrum Pressure injury Initially identified 12/9/2025 as a new Unstageable pressure ulcer in the CoccyxWound measurements: 4.96x 6.97 cm (surface area: Area31.23 cm^2)Classified as Unstageable pressure injury to coccyx and the site/wound location was changed to Sacrum on 12/9/2025Unstageable ulcer due to Slough and/or escharWound #3 - Rear Left thigh Pressure injury (Ischium)Initially identified on 12/17/2025 as a new Unstageable ulcerWound measurements: 3.97 cm x 2.68 cm (surface area: 7.91 cm^2)Classified and Described as an unstageable pressure injury presenting as a deep tissue injuryV7 was asked how she became aware of the wound on R5's right heel wound. V7 stated that a floor nurse reported to her that R5 had a wound on the right heel; however, she could not recall the name of the nurse who reported it. V7 further stated that she assessed the wound herself and identified it as a diabetic ulcer then classified as a Stage 4 pressure injury after re-assessment.V7 stated that certified nursing assistants (CNAs) check residents' skin while providing care, such as during showers. If they observe any wounds or changes in skin condition, they report their findings to the nurse for assessment and, if necessary, referral to the wound care team. However, V7 confirmed that there was no documentation showing R5's skin alteration prior to the identification of multiple facility-acquired pressure injuries.R5 was referred to V19 (Wound physician) for wound evaluation. V19 confirmed via phone call on 1/22/2026 at 11:52 AM that he saw and evaluated R5's pressure wounds.11/25/2025 seen for Right heel wound; wound report stated that the wound is Stage 4 pressure injury measuring 5.5x4.4 cm and depth is unmeasurable due to presence of nonviable tissue and necrosis12/9/2025 seen for Sacrum wound; wound report stated that the wound is Unstageable Necrosis measuring 5.0x7.0 cm and depth is unmeasurable due to presence of nonviable tissue and necrosis12/16/2025 seen for Left ischium: wound report stated that the wound is Unstageable Deep Tissue Injury (DTI) with intact skin measuring 4.0x2.7On 1/21/2026 at 1:46 PM, V15 (Registered Nurse/RN) stated that nurses complete weekly skin assessments, including head-to-toe assessments. V15 stated that assessments are often performed while CNAs are changing or bathing residents to allow for better visualization of the skin. V15 reported that nurses inspect the skin by removing garments to check for redness or open areas that are not being treated. V15 stated that findings are documented on a form that is completed and submitted to the wound care team, with the affected areas circled and signed by the nurse. V15 further stated that CNAs also report skin concerns to nursing staff. V15 said that even mild changes in skin condition are reported to the wound care team, which then provides treatment orders. V15 stated that any redness or skin changes should be reported promptly to prevent progression to more severe conditions, including Stage 4 pressure injuries, and that wounds should be treated immediately.On 1/22/2026 at 8:52 AM, V17 (RN) stated that certified nursing assistants check residents' skin during showers and while providing care. If any skin alterations are observed, they are reported to the nurse for assessment, and the nurse then relays the information to the wound care team. V17 further stated that regular skin assessments are important to identify wounds early, noting that pressure injuries typically begin with redness and can be addressed before progressing to a more severe stage like into a stage 4 pressure ulcer.On 1/22/2026 at 12:30 PM. V2 (Director of Nursing/DON) was interviewed (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	regarding R5. V2 was asked why there were no shower sheets documenting that R5 had skin conditions prior to the discovery of Stage 4 pressure injury to the right heel and unstageable wounds to Sacrum and Left ischium. V2 responded that CNAs may have assumed that nurses were already aware of R5's wounds and failed to notify the wound care team about it. V2 stated that reporting the wound earlier would have allowed proper treatment and believed the wound could not have worsened if reported sooner. V2 acknowledged that there was a lapse in reporting skin conditions and V2 emphasized that if a wound is pressure-related, it should be treated immediately or appropriately dressed to prevent progression and infection. V2 also agreed that a stage 4 pressure ulcer could not develop overnight, and therefore there should have been observable signs of skin alteration prior to the ulcer's development that was reported to the wound care team.V21's NP (Nurse Practitioner) note dated 12/15/2025 that the NP saw R5 due to ESBL (Extended-Spectrum Beta-Lactamase) infection of the right heel. Wound was swabbed (tested) on 12/9/2025 and final culture and sensitivity report came out positive for ESBL on 12/13/2025, R5 was referred to infectious disease doctor. The record further showed that R5 was started on intravenous (IV) antibiotics on 12/15/2025, for an infection of the right heel pressure injury, specifically Invanz (ertapenem) IV 1 gram daily for 10 days. The record also showed that R5 received intravenous antibiotic therapy with Unasyn 1.5 grams every 12 hours on November 14, 2025, for a right heel wound infection.According to nurse interviews, nurses reported performing complete weekly skin assessments, including head-to-toe assessments, which are often conducted while CNAs are changing or bathing residents to allow for better visualization of the skin. However, review of documentation revealed no shower sheets or assessment records indicating that R5's skin was assessed during showers or while care was being provided prior to discovering the wounds.The failure to identify early detection of skin conditions and alterations led to one (1) stage 4 and two (2) unstageable pressure injuries. Proper treatment and interventions were not put in place to possibly prevent wound worsening and infection. The lapse in reporting led to failure in providing treatment.POLICIES:Pressure Ulcer Treatment and Management Policy with a revised date of 5/2022, reads in part: Residents will receive treatment for pressure injuries.Residents with pressure ulcers will have a physician's order for treatment.A description of the wound will be maintained on a weekly basis.The licensed nurse will the document treatment as given on Treatment Administration Record.Pressure Ulcer Prevention Protocol with a revision date of 5/2018, reads in part: Resident will be assessed to determine their risk factor(s) for pressure ulcer development, upon admission and at least quarterly thereafter.Newly admitted or readmitted residents will have a Pressure Ulcer Risk Assessment completed upon admission, weekly thereafter for the next 3 weeks after admission.Interventions necessary to maintain skin integrity or to promote healing will be incorporated into the plan of care based on each residence individual needs and risk, which may include:Daily skin checks conducted by either the CNA or licensed Nurse to ensure early identification of potential problem areas.Plan of care to address mobility status and ability to reposition self.Use of Pressure Reducing Devices, such as pressure reducing mattresses, mattress overlays, w/c cushioning devices if needed.Determination of need for supplemental skin care such as barrier care or moisturizing lotion.Any other factor identified on the risk assessment including but not limited to nutritional support, positioning support devices or medication review.The resident care plan will indicate the resident's risk factor(s) and include individualized interventions as needed for a comprehensive pressure ulcer prevention program.Residents will have their skin checked and documented utilizing the Treatment Administration Record. This skin check will be performed at a minimum of weekly.Documentation:Pressure Sore Risk Assessment (Braden Scale)Skin Check DocumentationCare PlanPressure Ulcer Treatment and Management with a revised date of 5/2017, (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	reads in part:Residents with pressure ulcers will have a physician's order for treatment.A description of the wound will be maintained on a weekly basis.The licensed nurse will document the treatment as given on the Treatment Administration Record.A Skin Risk Assessment will be completed quarterly on all residents.The clinical record will indicate whether the resident was admitted with a pressure ulcer, or the ulcer was acquired in the facility.The plan of care will include the presence of the pressure ulcer and include the individual description of the treatment plan including pressure relief, turning and repositioning, additional nutritional measures, need for assistance with mobility and range of motion.The physician will be notified when the assessment indicates a lack of progress in healing.Residents with pressure ulcers will be determined to be high risk for pressure ulcer prevention and all components of the At-Risk protocol will include Pressure relieving devices, nutritional support, assistance with mobility including repositioning and ROM as outlined in the At Risk Procotol.The licensed nurse will perform the treatment utilizing standard precautions for infection control. Any wound drainage cultured wound necessitates the need to follow the CDC guidelines for isolation precaution as necessary.Documentation:Physician Order SheetSkin Risk AssessmentTreatment Administration RecordCare PlanWound Dressing Policy with a revised date of 5/2017, reads in part:Objectives: To provide an appropriate type of protective wound covering that facilitate the healing process.Procedure: Change dressing using clean technique according to physician orders. Frequency of wound dressing changes and the type of wound dressing will be specified in the physician's order.

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F 0689 Level of Harm - 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** Based on interview and record review, the facility failed to ensure a resident was properly secured while being transported using the facility's private transport vehicle. This failure affects one of three residents (R3) reviewed for falls. R3 fell forward inside the facility's private trasnport vehicle and sustained a right intertrochanteric femur fracture requiring surgical repair of Intramedullary nailing of the right proximal femur.Findings include:R3 admitted to the facility on [DATE] with diagnoses including Multiple Sclerosis and muscle wasting and atrophy.The Facility Reported Incident dated 11/11/25 reads in part: R3 experienced a fall from wheelchair during transport while in route back to the facility after an appointment. Upon returning to facility, R3 was assessed and complained of severe pain in right leg. Nurse practitioner present in the facility and ordered to send R3 out to emergency department via 911 (emergency transfer). R3 was transferred to local hospital. Hospital records indicate R3 sustained a right intertrochanter femur fracture.Summary of Investigation: R3 alert and oriented x 3 with periods of forgetfulness. R3 scored 13 on Brief Interview for Mental Status (BIMS) assessment and is able to make her needs known. V10 (CNA) stated R3's wheelchair was locked in place with seatbelt secured around R3. V10 verbalized while V10 was transporting the resident back to facility, V10 approached a red light and applied breaks. V10 stated in the rearview mirror, V10 observed R3 slide out of R3's wheelchair and onto the floor of the vehicle, landing on R3's buttocks. V10 immediately stopped and tended to R3. V10 verbalized R3 denied pain and assisted back R3 into the wheelchair. Upon arrival back in the facility, R3 reported leg pain. V10 said V10 promptly assisted R3 to bed and notified the nurse of the incident and complaints of pain. Nurse immediately assessed R3.Nurse (V8) stated V10 notified V8 that R3 slid out of R3's wheelchair during transport and onto the floor of the vehicle. V8 verbalized V10 stated R3 was back in bed and verbalized right leg pain. V8 assessed R3 and observed external rotation and shortening of resident right lower extremity.Per R3, once R3 arrived back to the facility, R3 started to feel severe pain in her right lower extremity and was assisted back to bed by V10.Conclusion: The facility determined R3 fall likely occurred from force applied to the vehicle breaks.On 1/20/26 at 2:45PM, R3 stated that V10 (CNA) was the driver of the vehicle. On their drive back in the facility, V10 abruptly pressed the break and R3 fell forward and landed on the vehicle floor. R3 stated R3's wheelchair was not strapped or properly secured. R3 also denied the seatbelt was applied on R3. R3 stated that R3 was sure that the wheelchair was not strapped and properly secured because as R3 fell forward, the wheelchair also moved and tipped over, landed and hit R3 on the head. V10 stopped the vehicle and asked R3 if R3 is okay and if there is any pain. R3 denied pain at the time, and V10 assisted R3 back onto the wheelchair. Upon arrival in the facility, R3 reported to V10 that R3 had right leg pain. V10 continued to take R3 in her room and transfer R3 back to bed. R3 then reported the nurse came in to assess her pain. R3 then reported to the nurse about the incident that happened during transport.Nurse Practitioner notes dated 11/10/25 at 1530, reads in part: R3 said R3 went to appointment with R3's physician and that R3 slipped out of her wheelchair and hit R3's head. R3 denies any headache but does have right hip pain. Upon assessment right hip looks shortened and externally rotated. R3 admits to pain when right hip assessed with abduction and adduction.On 1/20/26 at 12:30PM, V8 (RN) stated that R3 went for appointment and transported by V10 using the private facility vehicle. Denied getting a phone call from V10 regarding the accident during transport. V8 stated she was not even made aware that R3 had returned to the facility. It was just reported to V8 that R3 is complaining of pain, but V8 does not recall who the staff member was that reported the pain to V8. V8 stated she does not recall upon entering (continued on next page)

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