Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 05/05/2026
Form Approved OMB
No. 0938-0391

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	02/13/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. Based on observations, interviews, and record reviews, this facility failed to follow its call light policy and ensure the call light cord was within reach for 4 residents (R3, R5, R6, and R7) out of 4 residents reviewed for call light accessibility in a sample of 7. Findings include:On 2/13/26 at 9:45 AM, R3 was heard shouting hello from his room. This surveyor asked R3 if he needed assistance, R3 responded that he is uncomfortable sitting in the reclining chair and wants to go back to bed. R3 stated that he has been in this chair since 5:00 AM when he went to his dialysis treatment. R3's call light cord was observed between wall and folded floor mat behind head of bed. When questioned if he was able to use call light for assistance, responded yeah I can't find it. V2 DON (director of nursing) was called to R3's room. When V2 was asked where R3's call light cord was, V2 retrieved it from behind head of bed. V2 stated that the call light cord should be within R3's reach. On 2/13/26 at 11:45 AM, R5 was observed lying in bed. R5's call light cord was observed dangling on R5's wheelchair that was positioned on the right side of R5's bed. R5 stated that R5 does not know where his call light cord is. On 2/13/26 at 11:46 AM, R6 was observed sitting in wheelchair next to her bed. R6's call light cord was observed behind her wheelchair, not within reach. R6 stated that R6 does not know where his call light cord is. On 2/13/26 at 11:47 AM, R7 was observed sitting in wheelchair next to her roommate's bed. R7 stated that she does not know where her call light cord is. R7's call light cord was not within reach. The facility's call light policy, reviewed 06/2024, notes in part functioning call light placed where it is accessible to the resident.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145781	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2026

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 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. Based on observations, interviews, and record reviews, this facility failed to identify, evaluate and eliminate hazards, and provide adequate supervision to prevent an avoidable accident in accordance with current professional standards of practice for one residents (R4) out of three residents reviewed for avoidable falls in a sample of 7. Findings include:On 2/13/26 at 9:55 AM, R4 was observed lying on his right side on the floor near bathroom. R4's wheelchair was observed on the right side at the head of R4's bed. R4's bedside table was observed positioned in front of wheelchair. R4 was observed wearing regular socks instead of non-skid socks. R4 stated that he slid while walking to bathroom because of the socks he was wearing. This surveyor shouted out for assistance. V11 (nurse) came immediately to R4's room. V11 stated that she is not R4's nurse today but responded to the call for staff assistance. V11 obtained R4's vital signs and performed a head-to-toe assessment, R1 sustained an open area to his right lateral lower leg. V8 CNA (certified nurse aide) and V9 CNA came to R4's room. Both CNAs stated that R4 is not able to walk, he is able to self-transfer to wheelchair, self-propel into the bathroom then self-transfer onto toilet. V11 stated that R4 is not wearing appropriate socks. V11 stated that she was going to get R4's nurse and left R4's room. V11 returned shortly thereafter and stated, I'm his nurse today, I did not know. R4's assigned CNA, V10, came into R4's room. V10 stated that R4 is not able to walk, he is able to self-transfer to wheelchair, self-propel into bathroom then self-transfer onto toilet. V10 stated that she last rounded on R4 when she arrived at work at 7:00 AM.R4's admission fall risk assessment, dated 12/23/25, R4 with a history of falls in the past three months. R4 has intermittent confusion, is chairbound, and incontinent.R4's falls care plan, initiated 1/2/26, notes R4 is at high risk for falls related to gait/balance problems. Interventions identified include, in part, anticipate and meet R4's needs.R4's ADL (activities of daily living) care plan, initiated 12/26/25, notes R4 has an ADL self-care performance deficit related to impaired balance. Interventions identified include, in part, transfers - R4 requires supervision by one staff to move between surfaces. The facility's fall prevention and management policy, revised 12/2023, notes, in part, the fall prevention and management practices include separate activities: universal fall precautions, standardized assessment of fall risk factors, care planning, and post fall response. Universal fall precautions are safety measures that are taken to reduce the chance of falls for all residents, regardless of individual fall risks. The fall risk assessment is used to identify fall risk factors. A fall risk care plan will be implemented to address universal fall precautions and individual risk factors as applies to the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145781	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2026
NAME OF PROVIDER OR SUPPLIER Generations at Applewood		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observations, interviews, and record reviews, this facility failed to maintain its call light system in good working condition for one resident (R3) out of four residents reviewed for working call lights in a sample of 7. Findings include:On 2/13/26 at 9:45 AM, R3 was observed sitting in a reclining chair next to the bed closest to the door. R3's call light cord was observed between wall and folded floor mat behind head of bed. When questioned if he was able to use call light for assistance, responded yeah I can't find it. V2 DON (director of nursing) was called to R3's room. When V2 was asked where R3's call light cord was, V2 retrieved it from behind head of bed. V2 handed R3 call light button and R3 was asked to demonstrate how to use it. R3 pressed the call light button; the light did not activate in hallway above R3's door. R3 was asked to press again, the light still did not activate. R3 was given the call light cord for the bed furthest from the door and asked to press call light button, the light was activated in hallway above door. V2 stated that R3's call light does not work, and she will have it replaced. V2 stated that staff should be checking residents' call lights to ensure functioning properly. The facility's call light policy, reviewed 06/2024, notes functioning call light will be placed where it is accessible to the resident.