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	05/08/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, interview, and record review, the facility failed to follow its abuse prevention policy by neglecting to provide the necessary personal care and assistance with ADLs (activities of daily living) to meet the residents needs. This failure affected all 30 residents residing on one nursing unit. Findings include:On 5/6/26 at approximately 3:00 PM, this surveyor and V1 (administrator) observed the facility's video surveillance tape, dated 5/2/2026. At 10:10 PM, the video shows V8 CNA (certified nurse aide) pulling into the facility parking lot. Video shows V8 enter the facility at 11:43 PM. At 1:51 AM, it shows V8 getting into her vehicle and leaving the facility. Video surveillance shows V8 return and enter the facility at 4:39 AM. At 05:51 AM, video surveillance show V8 leave the facility again and return at 5:59 AM.On 5/5/26 at 2:26 PM, V8 CNA stated that she was scheduled to work a double shift on 5/2/2026 11:00 PM- 5/3/26 3:00PM. V8 stated that it was only her and V38 (nurse) present on side 3 nursing unit during the 11:00 PM-7:00 AM shift due to a CNA call-off. V8 stated that she did not do any checks or changes on any resident during her entire shift on 5/2/2026 11:00 PM-7:00 AM due to the CNA call-off. V8 stated that she did not provide any incontinence care to any residents that required two-person assistance. V8 said that she waited until 7:00 AM on 5/3/2026 to provide incontinence care for R1. V8 stated that R1 is severely contracted, and she wanted to make sure she provided safe care. V8 stated that the expectation is that all residents are provided with ADL (Activities of Daily Living) care every two hours and as needed. V8 stated that she takes her lunch break outside the facility in her car. V8 stated that sometimes she falls asleep in her car and comes back from her lunch break late. V8 stated she is the caregiver for her mom who falls frequently, and she sometimes leaves the facility on her lunch break to go home to check on her mom. V8 stated that her lunch break is thirty minutes. On 5/6/26 at 10:39 AM, V14 CNA stated that she worked 5/3/26 7:00 AM-3:00 PM shift. V14 stated that while she was making her rounds at 7:00 AM, V8 CNA was providing care to R1 with V21 CNA's assistance. V14 stated that ADL care should be rendered to residents every two hours and as needed. On 5/7/26 at 3:01 PM, V21 CNA stated that on 5/3/2026 at the start of his 7:00 AM-3:00PM shift V8 was standing at the nurses' station with her belongings and asked him if he could assist with resident care for R1. V21 said that when they entered R1's room, R1 was visibly soiled and wet. V21 stated that incontinence care should be rendered every two hours and as needed.On 5/7/26 at 9:50 AM, V2 DON (director of nursing) acknowledged that staff should be providing incontinence care and turning/repositioning residents every two hours and as needed.On 5/7/26 at 11:40 AM, V34 CNA stated that there are only two CNAs working on side 3 nursing unit today. V34 stated that she is assigned to provide care for 15 residents. V34 stated that of the 15 residents, ten are always incontinent. V34 stated that 12 of her assigned residents require two persons to assist with ADLs; she is able to provide care to three residents by herself. V34 stated that there are currently four residents with tracheostomies, R1, R10, R12, and R13, that always require two persons assist with all ADLs.On 5/7/26 at 2:58 PM, V35 CNA stated that she is assigned to provide care for 15 residents on side 3 nursing unit today. V35 stated that V34 assisted her with providing care to 12 of these residents; the other three residents she was able to provide care by herself.On 5/7/26 at 2:57 PM, V38 stated that she was scheduled to work 5/2/2026 (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	11:00 PM-700 AM shift. V38 stated that two CNAs were scheduled, but there was a CNA call-off leaving V38 and V8 on the unit alone to care for thirty residents. V38 stated that CNAs are expected to make rounds and provide incontinence care every two hours and as needed. V38 stated that V8 told her she was going on break around 1:45 AM. V8's facility timecard shows V8 clocked out for break at 1:51 AM. V38 stated that she received a phone call from V8 around 4:00 AM stating she had an emergency and would be back soon. V38 stated that she took her lunch break outside in her vehicle at 4:00 AM and set her alarm for thirty minutes. V38 stated that she walked back into the facility with V8 around 4:30 AM. V38 stated that she was unaware that V8 left the facility at 1:51 AM and again at 5:51 AM. V38 stated she answered the call lights but did not provide incontinence care to any resident. V38 said that she informed the residents that V8, the assigned CNA, was on break and the residents would get changed when V8 returned. V38's facility timecard shows she clocked in at 11:15 PM on 5/2/2026. V38's facility timecard shows she clocked out for break on 5/3/2026 at 4:15 AM and clocked back in at 4:41 AM on 5/3/2026. The facility's midnight census for 5/1/26 notes there were 124 residents in the facility. On 5/2/26 at 11:00 PM there were 30 residents residing on side 3 nursing unit. The facility's daily assignment sheet, dated 5/2/26, notes there were eight CNAs scheduled to work 11:00 PM-7:00 AM shift. V8 (CNA supervisor) and V42 CNA were scheduled to work on the side 3 nursing unit. V42 CNA called off. V34 CNA is written on schedule to work 4:00 AM-7:00 AM. There were a total of 26 CNAs working on 5/2/26.V34's (CNA) timecard for 5/2/26 does not note V34 worked any part of the 11:00 PM - 7:00 AM; V34 worked day shift. On 5/3/26, V34 clocked in at 6:56 AM and clocked out at 2:57 PM.V8's (CNA) timecard for 5/2/26 notes V8 clocked in at 11:43 PM; clocked out at 1:51 AM. V8 did not clock in upon returning to the facility at 4:39 AM.The facility assessment, updated March 2026, notes in part notes its typical daily staffing pattern, based on the average daily census of 121 residents. It notes the total number of CNAs needed for the average is 28.The facility's abuse prevention guidance policy, dated 10/2022, notes in part neglect means the failure to provide goods and services to a resident that are necessary to avoid physical harm, pain. mental anguish or emotional distress. Neglect means a facility's failure to provide, or willful withholding of, adequate medical care, mental health treatment, psychiatric rehabilitation, personal care, or assistance with activities of daily living that is necessary to avoid physical harm, mental anguish, or mental illness of a resident including deprivation of goods and services by staff.The facilities (ADL) Activities of Daily Living policy, undated, notes in part residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. The facility's protocol for turning and repositioning, dated 07/2018, notes in part residents that cannot assist themselves may be turned every two hours and/or as often as needed.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, the facility failed to follow its fall prevention and management policy and review and revise one resident's care plan after each fall. The facility also failed to implement effective interventions to eliminate or reduce resident's fall risk. This failure affects one resident (R3) out of three reviewed for falls in a sample of 36.Findings include:On 5/6/26 at 11:50 AM, V18 (restorative nurse) stated that she reviews risk management for any resident falls and does rounds asking staff if any resident has fallen in the past 24 hours. V18 stated that V2 DON (director of nursing) will alert her about a resident fall. V18 stated that she investigates each fall. V18 stated that she asks the resident if alert enough, checks for any staff witnesses. V18 stated that during the daily morning meeting IDT (interdisciplinary team) will determine what new interventions should be put in place. V18 stated that she is responsible for updating the resident's falls care plan after each fall. When questioned about what fall interventions were put in place after R3's fall on 2/23/26, V18 responded that she was not aware R3 fell. V18 stated that on 3/9, she placed larger floor mats on side of R3's bed. V18's documentation was reviewed with her. V18 acknowledged that she brought in a larger floor mat but R3 refused it. V18 was unable to verbalize if any other intervention was put in place. V18 stated that after R3's fall on 3/20 medication review was done due to R3's confusion at that time. V18 stated that V36 NP (nurse practitioner) decreased R3's trazodone medication from 50mg (milligrams) daily to 25mg daily. R3's trazodone medication orders were reviewed with V18; on 1/25/26 trazodone 50mg was discontinued and on 2/5 trazodone 25mg was ordered on an as needed basis only. V18 stated that on 3/26 an antibiotic was ordered for UTI (urinary tract infection). V18 was unable to provide any documentation that a urinalysis was done prior to initiating antibiotic. V18 stated that the root cause of R3's falls was due to her sitting up in bed. When questioned what fall prevention interventions should have been put in place, V18 responded frequent rounding was implemented after R3's fourth fall on 3/28. When questioned, V18 is unable to articulate what staff she spoke with after each fall, what were the predisposing factors, when R3 was last seen, and when did R3 last receive any pain medication/sedating medications.On 3/30/26 R3 was transported to the hospital and diagnosed with a right femur fracture.There is no documentation found in R3's medical record noting a root cause analysis was completed after each fall.The facility's comprehensive care plan policy, dated 04/2017, notes in part the comprehensive care plan will include: services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, psychosocial well-being while preventing decline; areas of potential risk to the resident with interventions to eliminate or reduce risk. Care plans are revised as changes in the resident's condition dictates.The facility's fall prevention and management policy, revised 12/2023, notes in part the development of the falls risk care plan is based on the results of the falls assessment as well as investigation of all circumstances and related resident outcomes. The falls care plan will be reviewed and revised with any fall event the resident might experience. In the medical record document the event, outcome, and initial and ongoing observations, and update fall risk assessment and care plan.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on interview and record review the facility failed to follow its ADL (Activities of Daily Living) policy and provide incontinence care and turning/repositioning for four residents (R1, R10, R12, and R13) who are totally dependent on two staff for all ADL care, with the potential to affect all 30 residents residing on one nursing unit.Findings include: On 5/6/26 at approximately 3:00 PM, this surveyor and V1 (administrator) observed video surveillance, dated 5/2/2026. At 10:10 PM, the video shows V8 CNA (certified nurse aide) pulling into the facility parking lot. Video shows V8 enter the facility at 11:43 PM. At 1:51 AM, video surveillance shows V8 getting into her vehicle and leaving the facility. Video surveillance shows V8 return and enter the facility at 4:39 AM. At 05:51 AM, video surveillance show V8 leave the facility again and return at 5:59 AM.On 5/5/26 at 2:26 PM, V8 CNA (certified nurse aide) stated that she was scheduled to work a double shift on 5/2/2026 11:00 PM-5/3/26 3:00PM. V8 stated that it was only her and V38 (nurse) present on side 3 nursing unit during the 11:00 PM-7:00 AM shift due to a CNA call-off.V8 stated that she did not do any checks or changes on any resident during her entire shift on 5/2/2026 11:00 PM-7:00 AM due to the CNA call-off on side 3 nursing unit. V8 stated that she did not provide any incontinence care to any residents that required two-person assistance. V8 said that she waited until 7:00 AM on 5/3/2026 to provide incontinent care for R1. V8 stated that R1 is severely contracted, and she wanted to make sure she provided safe care. V8 stated that the expectation is that all residents are provided ADL (Activities of Daily Living) care every two hours and as needed. V8 stated that she takes her lunch break outside the facility in her car. V8 stated that sometimes she falls asleep in her car and comes back from her lunch break late. V8 stated she is the caregiver for her mom who falls frequently, and she sometimes leaves the facility on her lunch break to go home to check on her mom. V8 stated that her lunch break is thirty minutes. On 5/6/26 at 10:39 AM, V14 CNA stated that she worked 5/3/26 7:00 AM;3:00 PM shift. V14 stated that while she was making her rounds, V8 CNA was providing care to R1 with V21 CNA's assistance. V14 stated that ADL care should be rendered to residents every two hours and as needed. On 5/7/26 at 3:01 PM, V21 CNA stated that on 5/3/2026 at the start of his 7:00 AM-3:00PM shift V8 was standing at the nurses station with her belongings and asked him if he could assist with resident care for R1. V21 said that when they entered R1's room, R1 was visibly soiled and wet. V21 stated that incontinence care should be rendered every two hours and as needed.On 5/7/26 at 9:50 AM, V2 DON (director of nursing) acknowledged that staff should be proving incontinence care and turning/repositioning residents every two hours and as needed.On 5/7/26 at 2:57 PM, V38 stated that she was scheduled to work 5/2/2026 11:00 PM-700 AM shift. V38 stated that two CNAs were scheduled, but there was a CNA call-off leaving V38 and V8 on the unit alone to care for thirty residents. V38 stated that CNAs are expected to make rounds and provide incontinence care every two hours and as needed. V38 stated that V8 told her she was going on break around 1:45 AM. V8's facility timecard shows V8 clocked out for break at 1:51 AM. V38 stated that she received a phone call from V8 around 4:00 AM stating she had an emergency and would be back soon. V38 stated that she took her lunch break outside in her vehicle at 4:00 AM and set her alarm for thirty minutes. V38 stated that she walked back into the facility with V8 around 4:30 AM. V38 stated that she was unaware that V8 left the facility at 1:51 AM and again at 5:51 AM on 5/3/2026 because she was busy providing care to her residents with g-tubes (gastrostomy tubes). V38 stated she answered the call lights but did not provide incontinence care to any resident. V38 said that she informed the residents that V8 the assigned CNA was on break and they would get changed when V8 returned. V38's facility timecard shows she clocked in at 11:15 PM on 5/2/2026. V38's facility timecard shows she clocked out for break on 5/3/2026 at 4:15 AM and clocked back in at 4:41 AM on 5/3/2026. The facilities (ADL) Activities of Daily Living policy, undated, notes in part residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. The facility's protocol for turning and repositioning, dated (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	07/2018, notes in part residents that cannot assist themselves may be turned every two hours and/or as often as needed.

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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 follow their fall policy by failing to implement effective fall interventions, failed to thoroughly investigate each fall to determine root cause analysis, failed to conduct fall risk assessments after two falls and failed to conduct neurological checks for one resident (R3) out of three reviewed for falls. These failures resulted in R3 sustaining four unwitnessed falls and being diagnosed with a right femur fracture.Findings include:R3 was admitted to the facility on [DATE] with a diagnosis of chronic obstructive pulmonary disease, type II diabetes, heart failure, osteoarthritis of knee unspecified, repeated falls, abnormalities of gait, malignant neoplasm of bronchus or lung and weakness.R3's fall risk evaluation dated 1/26/26 documents: R3 at high risk for falls due to score of 13. A score of 10 or greater, the resident should be considered at high risk for falls.R3 progress note dated 2/23/26 documents: Pain & Vitals: Resident complaints of pain in right shoulder. Refuses to go to the hospital. Hospice was called for recommendations. Hospice nurse suggested pain pill. Vitals are BP 196/61 P 58 R 19 SPO2 98. Hospice nurse will do a follow up. Level of consciousness (LOC) & Orientation: Resident alert and oriented times four. Skin assessment: No changes to skinRange of Motion: No change in all of range of motion. Description: Resident stated she was trying to get in her chair. When standing her ankles gave out and she fell forward. Resident stated she did not hit her head or is in any pain enough to go to the hospital. Resident refused hospital and hospice was called. Intervention: Norco given, resident changed and reposition in bed. Notifications (DON, Family, Provider): Hospice, Family, and DON aware.There was no documentation in R3's medical record following the fall on 2/23/26 for a fall risk assessment, new fall intervention, or investigation with root cause.R3 nursing progress note dated 3/8/26 documents: Around 10am resident was observed sitting on the floor on the mat. She was sitting on her buttocks beside her bed alert and ox3. When asked what had happened, she said she didn't know. Resident assessed for injury before being assisted up per mechanical lift by staff members. Nurse did a body check on resident she denied any pain or discomfort. No injuries were noticed. Notified Nurse Practitioner, family Vital signs monitoring. Neuro. signs stable.R3 nurse practitioner progress note dated 3/9/26 documents: Fall, initial - R3 was found on floor at 10 am she does not remember falling and appears vague when asked any questions in regard to why she was on floor. It is noted that R3 likes to sit on side of bed to help breathe. Patient will be getting a larger floor mat and will also ask pulmonology to evaluate to see if anything else can be done for breathing.R3 progress note dated 3/10/26 documents: Resident refusing a larger floor mat stating I don't want that in my room. Resident was educated on safety and the recent incidents resident stated I would rather fall on the floor. I don't want that large mat in my room.There was no documentation in R3's medical record following the fall on 3/826 for a fall risk assessment, new fall intervention after refusal of floor mat, or fall investigation with root cause.R3 progress note dated 3/20/26 documents: CNA notifies RN at 10:20pm RE unwitnessed/ uninjured fall event. Resident observed sitting on buttocks on top of floor mat perpendicular to bed. Resident had no clothing or socks on; took hospital gown off prior to fall. Mechanical lift used to put resident back to bed, performed full body assessment, and obtained vitals. Range of motion to all four ectremities(ROM x4). No complaints of pain or signs or symptoms of discomfort, or pain. Initiated neurological checks, vitals every 72 Hours, and increased monitoring. Notified daughter at 10:37pm, NP at 10:40pm, and DON at 11:02 for unwitnessed/uninjured fall event. Low bed position with fall precautions in place. Call light within reach.R3's fall risk evaluation dated 3/20/26 documents: R3 at high risk for falls due to score of 16. A score of 10 or greater, the resident should be considered at high risk for falls.R3's neurological assessment dated [DATE] does not documents any response under grips equal and moves all extremities or signature from times 11:35PM to 4:05AM. There was no documentation for 8:05AM and 12:05PM. Day two and day three no (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	documentation for 11-7 shift.There was no documentation in R3's medical record following the fall on 3/20/26 for a fall investigation with root cause. Intervention implemented was medication review.R3 progress notes dated 3/28/26 at 9:48PM documents: Unwitnessed fall in resident's room; heard moaning. Resident observed lying supine on floormat adjacent to bed in hospital gown, no footwear; continued to roll around on floor. Returned resident to bed and performed full body assessment, obtained vitals, and administered 2-5-325mg Norco related to moaning and complaints of right knee pain. Able to perform range of motion (ROM) x4. Low bed position with fall precautions in place: floor mat. Call light within reach.R3's fall risk evaluation dated 3/28/26 documents: R3 at high risk for falls due to score of 23. A score of 10 or greater, the resident should be considered at high risk for falls.There were no neurological checks following the fall on 3/28/26.R3 progress notes dated 3/29/26 at 1:35AM documents: Hospice that the resident had an unwitnessed fall at 9:48PM. The resident is moaning really loud and complaints of severe right knee pain. The resident reported that the Norco administered to her is not helping with the Pain. Writer did ask if the resident wanted to go to the hospital, she declined. Writer requested for Hospice to send a Hospice nurse to reassess to determine if the resident requires diagnostics and additional pain management or to be sent to the hospital for a higher level of care.Facility fall reportable dated 3/31/26 documents under conclusion documents: R3 attempted independent movement or repositioning, resulting in a unwitnessed fall from the bed despite safety interventions being in place. R3 has poor safety awareness related to her functional limitations, muscle weakness and medical comorbidities.Incidents by incident type report for R3 dated 2/1/26 to 5/5/26 documents: Fall on 3/8/26 at 10:00AM; notes R3 refused larger floor mat, education given to R3. Incident 3/20/26 at 10:20 Initiated neurological checks and increased monitoring. Incident on 3/28/26 at 9:48PM. No other falls listed. There was no other information related to investigation (staff interviews) or root cause of the falls. Facility (V2 (DON) and V18 (restorative nurse)) was asked to provide all information related to all of R3's falls during the survey. No other documentation was presented.On 5/6/26 at 11:44AM, V18 (restorative nurse) said after a fall they will conduct a risk management, fall risk are conducted after the falls, care plans are updated with new interventions. V18 was asked to provide any other information related to R3 falls from February to discharge. V18 was unable to provide any documentation related to the fall investigation, interviews or root cause of falls for R3. V18 said the root cause for all of R3's falls was that she sat at the edge of the bed. V18 said interventions placed after fall on 3/8/26 were larger floor mats; after fall 3/20/26 was medication review; after fall 3/28/26 frequent rounding. V18 said R3 refused larger floor mats. V18 was unable to say how these interventions placed were effective related to the root cause of sitting on edge of the bed. At 12:25PM, V18 provided a note from V36 (NP) about medication change related to trazadone. V18 was informed that R3's trazadone was changed on 2/5/26 and was unable to provide documentation related to medication review.On 5/5/26 at 12:41PM, V2 (DON) said fall risk are completed upon admission, quarterly and after every fall. V2 said fall care plan are updated by V18 (restorative nurse) the following business day if on the weekend or the same day if during the week and present at the facility. V2 said neuro checks are conducted on every resident following an unwitnessed fall. The neuro check form should be completed and signed off by staff. V2 unsure if they had any other neuro checks for R3. V2 said falls are investigated and a root cause of the fall is determined to ensure that the interventions placed are effective to prevent another fall. On 5/6/26 at 3:32PM, V2 (DON) presented a progress note dated 3/26/26 documenting: R3 was started on cipro for possible urinary track infection for medication review after fall on 3/20/26.R3's hospital report dated 3/30/26 documents presents for evaluation of altered mental status. R3 was last well on the March 25th and that since then she has been acting progressively more altered. Under general appearance: musculoskeletal internal rotation to right lower extremity. Under attestation documents: R3 had fall two days ago that has not been yet evaluated. They report R3 has been signaling that she is having pain to the right leg. On exam ill appearing. She does have deformity to her right lower extremity. Hospital x-ray of right femur documents: acute comminuted fracture of the distal femoral (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	metaphysis with posterior displacement and angulation.R3's plan of care dated 1/26/26 risk for falls documents: assist resident with ambulation and transfer, utilizing therapy recommendations; evaluate fall risk on admission and as needed; if fall occurs alert provider, if fall occurs initiate frequent neuro and bleeding evaluation per facility protocol; if resident a fall risk, initiate fall risk precautions. Care plan dated 1/27/25 documents resident is high risk for falls related to gait/balance problems. Interventions documented: anticipate and meet the need of the residents; be sure call light is within reach and encourage resident to use it for assistance as needed; educate the resident/family abut safety reminders dated 10.22.25; frequent rounding dated 3.28.26; larger floor mats dated 3.9.26; medication review dated 1.26.26 and 3.23.26; offer resident to lay down before dinner dated 11.17.25; physical therapy evaluate and treat; review information of past falls and attempt to determine cause of falls. Record possible root causes. After remove any potential causes if possible. Educate resident/family as to causes dated 10/22/25; wedges to left side of bed dated 12.1.25.Facility fall prevention and management policy revised documents 12/23: the purpose of this policy is to support the prevention of falls by implementation of a preventative program that promotes the safety of residents based on care processes that represent the best ways we currently know of preventing falls. The falls prevention and management program is designed to assist staff in providing individualized, person-centered care. The falls prevention and management program provided framework and tools to identify and communicate about a resident's risk for falls. The fall risk assessments is completed quarterly, with significant change in condition or following a fall event. The fall risk assessment is used to identify fall risk factors. Under care planning and interventions: Development of the fall risk care plan is based on results of the fall assessment as well as the investigation of all circumstances and related resident outcomes. The care plan addresses universal fall precautions and individual fall risk factors that apply to the resident. The care plan will be revised and reviewed at least quarterly and with any fall event the resident might experience. Staff shall maintain communication with appropriate personnel when situations or resident behaviors suggest that the current intervention is not effective. The facility shall re-evaluate as needed to promote safety.

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	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Generations at Applewood	21020 Kostner Avenue Matteson, IL 60443

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F 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow their pain policy and provide effective pain management for one resident experiencing severe right knee pain after a fourth unwitnessed fall. These failures affect one of three residents (R3) reviewed for pain management. These failures resulted in the resident experiencing severe pain, revoking hospice services and being transferred to the hospital with a diagnosis of right femur fracture.Findings include:R3 was admitted to the facility on [DATE] with a diagnosis of chronic obstructive pulmonary disease, type II diabetes, heart failure, osteoarthritis of knee unspecified, repeated falls, abnormalities of gait, malignant neoplasm of bronchus or lung and weakness.R3 progress notes dated 3/28/26 at 9:48PM documents: Unwitnessed fall in resident's room; heard moaning. Resident observed lying supine on floormat adjacent to bed in hospital gown, no footwear; continued to roll around on floor. Returned resident to bed and performed full body assessment, obtained vitals, and administered 2-5-325mg Norco related to moaning and complaints of right knee pain. Able to perform range of motion (ROM) x4. Low bed position with fall precautions in place: floor mat. Call light within reach.On 5/5/26 at 3:37PM, V10 (nurse) who was assigned to R3 for falls on 3/28/26 said R3 said she had pain in her right knee cap. V10 said she performed range of motion in all 4 extremities after each fall with no concerns with movement observed. V10 said R3 had norco for pain and did not have any morphine on hand at that time. V10 said they would recheck pain after an hour to see if effective and document. If medication was not effective they would call the doctor. V10 unable to recall if she called the doctor about R3's pain.R3 progress notes dated 3/29/26 at 1:35AM documents: Hospice that the resident had an unwitnessed fall at 9:48PM. The resident is moaning really loud and complaints of severe right knee pain. The resident reported that the Norco administered to her is not helping with the Pain. Writer did ask if the resident wanted to go to the hospital, she declined. Writer requested for Hospice to send a Hospice nurse to reassess to determine if the resident requires diagnostics and additional pain management or to be sent to the hospital for a higher level of care.Hospice nurse visit 3/29/26 at 2:47AM, pain documented 7/10. R3 fell and is complaining of right knee pain. Patient received norco but still moaning and groaning in pain. Under pain worst level of pain in last 24 hours was a nine. Constant severe pain to her right knee after fall. R3 described pain as aching, pressure, shooting sore taut throbbing. Norco was given but pain still extreme morphine and Ativan ordered stat. Facility might do x-ray. Under narrative: facility nurse called at 1:30 on 3/29/26 to report an unwitnessed fall at 9:00 pm on 3/28/26. Facility nurse reported that R3 is in extreme pain and think patient may have fractured her right leg or knee. Facility nurse administrated norco but the pain is still extreme. Comfort kit ordered stat.R3 progress notes dated 3/29/26 at 8:52AM documents: Writer administered 0.25ml Morphine Liquid to the resident. R3 progress notes dated 3/29/26 at 9:00AM documents: Resident is in extreme severe Pain.R3 progress note dated 3/29/26 3:31PM documents: Administered 2-5-325mg Norco at 3:31pm related to moaning out loud; effective. R3 order notes under Norco 5/325 take two tablets every 6 hours as needed severe pain ,moaning.R3 fall follow up note dated 3/29/26 at 5:09PM, vocal moaning, alert to self.R3 order administration note dated 3/29/26 9:31pm documents Norco 5/325 one tab given related to comfort care.Hospice nurse visit dated 3/30/26 documents pain 7/10 as numbness and stabbing. All activities exacerbate her pain. Patient in bed drowsy minimal responsive to writer. R3 post fall over 24 hours ago with complaint of pain to right knee medicated prior to arrival. No visible signs of pain.R3 order administration note dated 3/30/26 at 3:29PM Ativan given for restlessness.R3 progress note dated 3/30/26 at 4:21PM documents: Resident received early am lethargic but responsive to tactile and verbal stimuli. Resident not talking but making sounds noises. Assisted to wash face and give oral mouth care. Resident became more alert later after lunch, she is not eating she was able to take her meds crush with applesauce. Resident complaining of right knee pain and moaning when she received her ADL care and turning. Right knee tender upon touch. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Resident remained moaning and became restless only saying the word OH. Lorazepam 0.25cc given PO 2:50 PM. V36 (NP) and ADON made aware of present condition. Warm pack applied to right knee. V36(NP) said she will contact Hospice and family.R3's progress note dated 3/30/26 at 4:30PM by V36(NP) documents: R3 had fall over weekend on 3/29 and was complaining of pain to right knee. Hospice was notified and did ok for x-ray to right knee. Pt was moaning and in alot of pain over weekend even with norco so R3 was given morphine and can have ativan as needed. R3 seen this am sleeping moderately hard to arouse. She does open eyes but is non verbal only moaning when name called. R3 had been given some morphine to help with right knee pain. She took some norco over the weekend but was not strong enough with R3 still having a lot of pain and was given morphine. R3 normally alert and answers questions appropriately. Fall, initial - R3 had a fall on 3/28 per staff they contacted Hospice. The resident was moaning really loud and complaints of severe right knee pain. The resident reported that the Norco administered to her was not helping with the Pain. Writer did ask if the resident wanted to go to the hospital, she declined. Writer requested for Hospice to send a Hospice RN to reassess to determine if the resident requires diagnostics and additional pain management or to be sent to the hospital for a higher level of care. Per staff R3 has refused going to hospital. She is seen in room with ice pack on right knee and moaning hospice did order x-ray awaiting on results.R3's order administration note dated 3/30/26 at 8:29PM documents: Ativan ineffective.R3's nursing note dated 3/30/26 at 8:33PM, R3 transferred to local hospital per family request.On 5/8/26 at 10:29AM, V36 (Nurse practitioner) said she saw R3 on Monday (3/30/26) after the fall over the weekend. V36 said she did see R3 but did not do range on motion on R3's leg due to complaints of pain. V36 said it did not appear to be swollen but difficult to assess due to her size. V36 said she was made aware by staff nurse about getting an x-ray but unsure if it was done. V36 said R3 was not really talking and had been medicated prior to arrival. V36 said she would expect staff to medicate R3 as ordered for pain and reassess pain after administration of medication. V36 said she would expect staff to reassess after an hour and if not effective to contact hospice or physician related to pain not being controlled. V36 said she recall asking staff to administer morphine during visit to keep R3 comfortable. V36 said she spoke to the daughter about changes and that they were monitoring and R3 was declining. Family decided later that day to revoke hospice and she went to the hospital.R3's hospital report dated 3/30/26 documents presents for evaluation of altered mental status. R3 was last well on the March 25th and that since then she has been acting progressively more altered. Under general appearance: musculoskeletal internal rotation to right lower extremity. Under attestation documents: R3 had fall two days ago that has not been yet evaluated. They report R3 has been signaling that she is having pain to the right leg. On exam ill appearing. She does have deformity to her right lower extremity. Hospital x-ray of right femur documents: acute comminuted fracture of the distal femoral metaphysis with posterior displacement and angulation.On 5/8/26 at 12:11PM, V2(DON) said on 3/30/26 R3 was not decisional and would have good and bad days. V2 said they were unsure if R3 was experiencing terminal restlessness. Facility nurse reported that R3 was comfortable that day and no other concerns reported. V2 said not all comfort kits are ordered at admission. V2 said Staff are expected to have ordered pain medication on hand for residents. Staff are expected to administrator pain medication as ordered and evaluate pain at time of administration. Within an hour they are expected to follow up with the resident to ensure medication was effective and reassess pain. They can give verbal pain score and the information would be documented in the medication record. Staff are expected to inform the physician or hospice if pain is not controlled and should administrator medication if available as needed to provide comfort to the resident. Staff should also provide non pharmacologic interventions for pain.R3 controlled drug receipt form dated 3/1/26 for hydrocodone 5/325mg documents: 3/4/26 two tablets given; 3/5/26 one tablet given; 3/7/26 one tablet given, 3/8/26 one tablet given, 3/9/26 one tablet given, 3/11/26 one tablet given, 3/12/26 one tablet given, 3/13/26 one tablet given, 3/15/26 two tablets given; 3/16/26 two tablets given; 3/18/26 two tablets given; 3/19/26 two tablets given; 3/23/26 two tablets given; 3/28/26 at 9:23AM (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	and 9:44PM, two tablets given; 3/29/26 at 2:00AM, two tablets given, at 8:15AM, one tablet given, at 3:31PM two tablets given and at 9:31PM one tablets was given. That was the last dose of medication with zero tablets remaining.R3's medication administration record for march 2026 documents under hydrocodone 5/325mg give two tablets by mouth as needed for severe pain with start date 10/8/25 the following: on 3/28/26 at 9:43PM pain of seven, on 3/29/26 at 2:00AM a pain level of ten and at 3:31PM a pain level of six.R3's medication administration record for march 2026 documents under hydrocodone 5/325mg give one tablets by mouth as needed for pain with start date 10/8/25 the following: on 3/28/26 at 9:24M pain of eight, on 3/29/26 at 8:18AM a pain level of five and at 9:31PM a pain level of two.R3's medication administration record (MAR) for march 2026 documents under morphine sulfate 20mg/ml give 0.25 ML by mouth every one hour as needed for severe pain with start date 3/29/26: given 3/29/26 at 9:00AM a pain level of ten. No other entries documented.R3's physician order sheet dated 3/1/26- 4/30/26 documents: morphine sulfate 20mg/ml give 0.25 ML by mouth every one hour as needed for severe pain with start date 3/29/26.On 5/8/26 at 11:34AM, V41 (pharmacist) said thirty tablets of hydrocodone were delivered on 2/28/26. V41 said no other requests were made or sent for medication. V41 said on 3/29/26 morphine was taken from the emergency medication box for R3 to include two doses. No other requests were made or sent for R3.R3' s plan of care dated 2/14/25 documents: At risk for pain related to osteoarthritis/pain in joints/malignant neoplasm of the lungs. Interventions include; encourage a nap if experiencing fatigue; give pain medications as per physician orders; notify the physician if pain medications are ineffective; vital signs as ordered and as warranted, notify physician of any abnormalitiesFacility pain management policy revised 4/2025 documents: it is the policy of this facility to screen all residents for pain. Identify those who are experiencing pain and assess and develop an effective individualized pain management care plan. Acute pain refers to pain that is usually sudden in onset and time limited with a duration of less than one month and often is caused by trauma or medical treatments such as surgery. Pain assessment is more in -depth evaluation that occurs when residents reports presence of pain. Initial pain includes history of pain, history of addition, characteristics of pain such as intensity, pattern, location, frequency and duration, impact of pain on quality of life (sleeping, appetite, mood, factors such as activities, care or treatment that exacerbate pain as well as those that reduce pain, additional symptoms associated with pain. Physical and psychosocial issues an goals for pain management. Pain reassessment, the patient and resident should be reassessed for pain and side effects, adverse events produced by treatment and the impact of pain on resident. Pain management is a comprehensive approach to the needs of patient who experience problems associated with acute or chronic pain. Comfort goal: this is the goal for pain management that is developed individually with each resident and may include that the patient: verbalizes satisfaction with pain management; verbalizes pain relief; side effects remain minimal; functional status is maintained or improved. A comprehensive pain assessment is done on admission, quarterly and with each report of new or changed pain. The provider will be informed of the resident's initial complaint of pain and review pain management during routine visits. Documentation of the effectiveness of the pain management program can be found on the medication administration record or in the nursing note.