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	07/01/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, the facility failed to notify family and the attending physician of a dental appointment with procedure scheduled outside of the facility. These failures affects one resident (R2) of three residents reviewed for family and physician notification for changes.Findings include:R2's Face Sheet states V4 and V22 are listed as POA (Power of Attorney) with V22 listed as the first emergency contact.R2's medical record documents R2 went out of the facility for a dental appointment on 6/1/26 and returned to facility. Staff could not control the bleeding from R2's gums. Emergency Response (911) was called and R2 was admitted to the hospital with a diagnosis of Oral Hemorrhage.On 6/9/26 at 11:45AM, V7 (Certified Nursing Assistant (CNA)/Supervisor/Scheduler) stated V7 recalls scheduling the dental appointment for R2 and informing a nurse but V7 could not recall who the nurse was.On 6/9/26 at 12:30PM, V8 (RN) stated it is the scheduler who schedules the appointments that will inform the family. V8 stated most of the time, the staff don't even know that a resident has an appointment until the day of the appointment.On 6/9/26 at 1:30PM, V10 (ADON) stated R2 went to his dental appointment and returned to the facility with bleeding gums. Staff could not control the bleeding and R2 was sent out via 911 to hospital. V10 spoke with V4 and V22 and both verbalized concerns with lack of communication as they stated the facility did not notify them about the dental appointment nor did they receive any communication from the dental facility.On 6/10/26 at 11:35AM, V2 (DON) stated that the chief nurse was in the facility last week along with V10, and they acknowledged the deficiency and initiated corrective action. V2 stated R2's POA was not notified of the dental appointment and tooth extraction for R2.On 6/30/26 at 10AM, V4 (POA-Alternate) stated that V4 was not made aware of a dental appointment on 6/1/26. V4 stated the facility nor dental office contacted V4 to get consent for tooth extraction.On 6/30/26 at 10:25AM, V22 (POA-Emergency contact 1) stated that V22 was not made aware of any dental appointment and stated they would have come and meet R2 for his appointment if they had known. V22 stated the facility nor dental office called V22 to ask for consent for the tooth extraction.The facility's Change in a Resident's Condition or Status policy with a review date of 6/2024, reads in part: Facility shall promptly notify the residents, his or her attending physician and representative of any changes in the resident's condition and/or status. The nurse will notify the residents attending physician or physician extender when there is a need to alter the resident's treatment significantly; and deems necessary or appropriate in the best interest of the residents.

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify R2's attending physician of a scheduled extensive dental extraction procedure. The facility also failed to communicate with the cardiologist and/or attending physician of R2's use of multiple blood thinning medications and request orders related to these medications in relation to R2's scheduled extensive dental extraction procedure. These failures affect one resident (R2) of three residents reviewed for quality of care. These failures caused R2 to experience uncontrolled hemorrhaging from R2's gums/oral cavity after having extensive extraction of ten teeth. R2 required emergent transfer to the local hospital. R2 was admitted from the emergency room to the hospital with a diagnosis of Oral Hemorrhage requiring transfusion of multiple blood products.Findings include:R2's Hospital Record dated 6/1/2026, reads in part: R2 presents to Emergency Department by EMS (Emergency Medical Services) from nursing facility with a chief concern of oral bleeding. Following initial history and physical examination, local pressure was applied to the bleeding area with 4 by 4 gauze and having R2 to clench down with his jaw. This provided some initial relief of the active bleeding and slowed the bleeding down a small amount. With R2's large volume blood loss at the nursing facility described by family and the blood loss witnessed in our emergency department, decision was made to empirically transfuse the patient with a balanced transfusion of 1 unit of blood cells, 1 of platelets, 1 of FFP (Fresh Frozen Plasma). R2's anticoagulation was also reversed with prothrombin complex concentrate, human-[NAME] (Intravenous medication that contains blood clotting factors and used to rapidly reverse the effect of blood-thinning medications.)R2's medical record documents R2 went out of the facility for a dental appointment on 6/1/26 and returned to facility. Staff could not control the bleeding from R2's gums. Emergency Response (911) was called and R2 was admitted to the hospital with a diagnosis of Oral Hemorrhage.On 6/10/2026 at 10:20AM, V13 (Dentist) stated that the dental facility is aware that R2 is on anti-coagulant medications. V13 stated it is the facility's physician that can order to put anticoagulant medication on hold and that it is the physician's decision. V13 stated the dental office did not communicate any recommendation or any pre-procedure guidance or instruction to the facility or R2's physician. V13 stated that the facility already knew the reason for the appointment was for tooth extraction and should have communicated this to R2's physician. V13 stated that R2 consented for new dentures and consented to the extraction of 10 teeth on 6/1/2026.R2's Medical Records document R2's cognition as moderately cognitively impaired.R2's Dental Notes dated 6/1/2026 reads that dental office reviewed medication and that 10 teeth were extracted. These notes also document hemostasis was obtained before R2 was dismissed (back to the skilled nursing facility.)On 6/30/2026 at 12:00PM, V23 (Nurse Practitioner of Cardiology) stated that V23 gave clearance on 1/27/2026 with order to hold Apixaban two days before the procedure and hold Acetylsalicylic Acid 5 days before the procedure. There was no scheduled tooth extraction appointment date at the time of V23's visit on 1/27/2026. V23 also stated that on 2/24/2026, V24 (Nurse Practitioner of R2's Attending Physician) contacted V23 about the clearance for tooth extraction due to R2's Power of Attorney (POA) asking. V23 stated V23 instructed V24 to hold Apixaban for two days and Aspirin for five days prior to the procedure. V23 also stated V23 was made aware of R2 needing a tooth extraction but V23 considered this as low-risk procedure since it was not for multiple teeth extraction, which would have been a high-risk procedure. V23 stated V23 did not receive notification once the dental appointment for the tooth extraction was scheduled. V23 stated no one from the facility informed V23 that there was a set date for the tooth extraction for R2. V23 stated it is V23's expectation that the facility informed V23 of the tooth extraction date. V23 stated, If (I) had known the date of the tooth extraction appointment, (I) would have definitely continue with the order of holding the anticoagulant medication prior to procedure. V23 stated she was only aware of plans to extract a tooth, but not aware of the plan for multiple teeth to be extracted on the same day dental appointment.On 6/30/2026 at 1:00PM, V25 (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	(Attending Physician) stated that V25 was not made aware of the set date for tooth extraction appointment. V25 stated that his expectation is for the facility to inform him of the set date for the tooth extraction procedure. If V25 was made aware, they have protocol such as putting anticoagulant medication on hold prior to the procedure. V25 stated he would have given orders to hold R2's Apixaban for three days and Acetylsalicylic Acid for seven days prior to R2's extraction of multiple teeth. V25 also stated that one tooth extraction is more than enough to cause bleeding, and so it is important to hold blood thinner medication prior to procedure. V25 stated that R2 required at least one or two units of blood transfusion during R2's hospital stay for Oral Hemorrhage.On 6/30/2026 at 1:20PM, V24 (Nurse Practitioner of Attending Physician) stated she was not made aware of the set date appointment for R2's tooth extraction nor made aware of multiple teeth being extracted. V24 stated V24 was aware of possible tooth extraction, but not multiple. V24 stated that the resident received at least one unit of blood and plasma to help reverse R2's oral hemorrhaging. V24 also denied receiving a call from the dental office regarding tooth extraction or receiving written communication informing them/the facility of the plan.On 7/1/2026 at 12PM, V2 Director of Nursing (DON) stated once an appointment is scheduled, the nurses are to notify the resident's family and attending physician. V2 stated this will give the facility/physicians the opportunity to review resident's records and give/receive orders to hold or discontinue anything that is necessary.R2's Physician Order Sheet (POS) does not document an order to hold any medication prior to R2's dental procedure/tooth extraction.The facility's Change in a Resident's Condition or Status policy with a review date of 6/2024, reads in part: Facility shall promptly notify the residents, his or her attending physician and representative of any changes in the resident's condition and/or status. The nurse will notify the residents attending physician or physician extender when there is a need to alter the resident's treatment significantly; and deems necessary or appropriate in the best interest of the residents.