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	07/02/2026

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.

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Failures at this level required more than one deficient practice statement.A. Based on interview and record review, the facility failed to assess and document resident vital signs for a resident experiencing a change in condition and failed to ensure a resident received timely emergency treatment for one resident reviewed on the sample list of 33. These failures resulted in R7's delay in transferring to a higher level of care to receive emergency care after R7's change in condition.B. Based on observation, interview and record review, the facility failed to implement skin prevention interventions and failed to identify skin integrity impairments for two residents reviewed for skin integrity. These failures affect two residents (R32, R89) reviewed for skin integrity on the sample list of 33.C. Based on observation, interview and record review, the facility failed to ensure medications administered are documented at the time of administration. The facility also failed to ensure that medications were administered timely. These failures affect R47, R69, R73, R104 on the sample list of 33.Findings include: a) R7's face sheet documents R7 admitted to the facility on [DATE] with diagnoses including Chronic Respiratory Failure with Hypoxia, Unspecified Severe Protein-Calorie Malnutrition, Unspecified Asthma, Uncomplicated, Dependence on Respirator [Ventilator] Status, Pressure Ulcer of Sacral Region, Stage 4, Dysphagia, Oropharyngeal Phase, Encounter for Attention to Gastrostomy, Pressure Ulcer of Other Site, Unstageable , Encounterf for Attention to Tracheostomy, Dependence on Renal Dialysis, Hypothyroidism, Unspecified, End Stage Renal Disease, Gastro-Esophageal Reflux Disease Without Esophagitis , Hypotension, Unspecified , Other Specified Symptoms and Signs Involving The Digestive System and Abdomen (Ct Scan [DATE] Suggestive of Contained Perforation, Treated Surgically, Noninfective Gastroenteritis and Colitis, Unspecified, Perforation of Intestine (Nontraumatic) -Treated [DATE] Peritoneal Abscess - Treated with laparotomy and drainage [DATE]. R7's minimum data set ([DATE]) does not document a brief interview of mental status summary score and is marked not assessed. R7 had moderate impairment with cognition regarding decision making and had unclear speech. R7 utilized a feeding tube for nutrition and 51% or more of R7's nutrition was received through the tube feeding. R7's care plan ([DATE]) documents R7 requires tube feeding due to dysphagia, nothing by mouth (NPO) and is ventilator/trach dependent. The goal of care was R7 would be free of aspiration. Interventions to meet this goal include the head of the bed elevated to prevent aspiration, Monitor/document/report as needed any signs/symptoms of aspiration including- fever, shortness of breath, feeding tube dislodged, infection at tube site, self-extubating, feeding tube dysfunction or malfunction, abnormal breath/lung sounds, abnormal lab values, abdominal pain, distension, tenderness, constipation or fecal impaction, diarrhea, nausea/vomiting, dehydration. (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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On [DATE] at 11:45 AM V7 (Wound Nurse) stated she had already assessed R32 earlier this morning and identified a wound to the right foot. V7 described it as a diabetic foot ulcer to the right plantar lateral foot. There was a dressing on the right foot dated [DATE]. The dressing was removed, and a pink open area was observed on the plantar aspect of the right lateral foot. Surveyor asked V7 about the ulceration on the left heel. V7 stated she was unaware of any skin problem with the left heel. I looked at R32 earlier this morning and didn't see anything. Surveyor pointed to R32's left heel where an alteration in skin integrity was observed. R32 stated, That thing on my left heel has been there for a while. A sock on my foot makes it hurt. V7 described the left heel as a one centimeter (1 cm) by one point two centimeter (1.2 cm) pressure point diabetic ulcer. R32 stated, I had complained of the left heel bothering him, but no one has looked at my left or right foot before today. V39 (Wound Certified Nursing Assistant/CNA) stated V39 works on the floor as a CNA and works with wounds. V39 was familiar with R32. V39 stated neither as a CNA working on the floor, or a wound CNA, had V39 previously identified any issue with R32's feet. V39 stated staff are supposed to be looking at residents' skin. If there is a change or concern, it is reported to the nurse who then enters a report in the electronic health record (EHR). The EHR entry becomes the trigger for wound nursing to see the resident. V6 (Wound Nurse Coordinator) stated R32's left heel could be a pressure injury. V6 stated last week, R32 had no skin changes. V6 stated R32's right foot appears to be arterial; the left foot appears to be pressure related. V40 (Wound Nurse Practitioner) stated that R32 had a previous wound to the left foot which resolved on [DATE]. V40 stated R32's left heel is a diabetic foot wound. When surveyor asked how V40 differentiates diabetic foot ulcer from pressure injury, V40 stated because he has diabetes. If he has diabetes, it is a diabetic ulcer. V40 went on to state that R32's left foot could be multifactorial. V40 stated the left foot would not look any different if it was a pressure ulcer, rather than a diabetic ulcer. V40 stated I don't know what R32 looked like before. V40 stated that the risk to R32 is infection and R32 may need a debridement. V40 stated the expectation is that the CNAs are identifying skin and wound concerns and escalating those concerns to the nurse. On [DATE] at 2:04 PM V3 (Assistant Director of Nursing/DON) stated the wound nurse did not discuss R89's alteration in skin integrity with V3. V3 stated no staff in-service is planned regarding R89's alteration in skin integrity and preventing recurrence with R89 or another resident. On [DATE] at 9:15 AM V2 (Director of Nursing) stated V2 was aware of wound on R89's back. V2 stated R89's wound was related to sheer forces of staff pulling the mechanical lift sheet and R89's clothes out from under R89. V2 is developing staff education to prevent additional alterations in skin integrity for R89 or any other resident in the facility. Facility policy titled Wound Assessment with no date stated in part the facility will ensure that all residents with actual or potential skin integrity issues receive a timely, comprehensive, and ongoing wound assessment performed by licensing nursing staff. A full assessment will be completed with any new wound or any significant change in condition of the wound. c) On [DATE] at 11:48am, V14 (Licensed Practical Nurse) was observed administering 9:00am medications. Surveyor also noted that multiple residents were highlighted red (indicating late administration) on the screen displaying the EMAR (Electronic Medication Administration Records). Surveyor inquired why 16 residents were highlighted red on the EMAR V14 stated I (V14) got at least a couple more people to do from this morning, I'm (V4) passing 9:00am medication. Surveyor inquired why R73 was highlighted red on the EMAR. V14 responded, She's (R73) done already and proceeded to document R73's 9:00am medications at this time. Surveyor inquired who else (assigned to V14) had not received prescribed (9:00am) medications today V14 a[

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon observations, interviews, and record review the facility failed to implement preventive interventions to maintain skin integrity, failed to ensure that the LALM (Low Air Loss Mattress) as on the correct settings while in use, failed to ensure that multiple linen layers were not beneath the resident while on a LALM, failed to timely identify skin integrity impairments, failed to follow physician orders, and/or failed to document/administer prescribed treatments for 10 of 33 residents (R8, R11, R12, R47, R52, R55, R90, R100, R118, R121, R123) in the sample reviewed for pressure ulcers. These failures resulted in R118 developing a (facility acquired) infected (stage 4) sacral wound on or about 5/5/26 which required hospitalization, antibiotic medication, and surgical debridement. Findings include: R118 was admitted to the facility on [DATE]. R118's diagnoses include type II diabetes mellitus, generalized weakness, and (4/14/26) sacral pressure ulcer - stage 4. R118's (4/10/26) functional assessment affirms the resident is dependent on staff for rolling left and right. R118's (4/14/26) initial sacrum wound assessment states (in-house acquired) stage 3 pressure ulcer injury: Full-thickness skin loss therefore the wound was not identified timely as MASD (Moisture Associated Skin Damage) or stage 1 - as warranted. 3.27cm (centimeters) x 3.91cm x 0cm. Wound bed: 90% granulation. Exudate: serosanguinous: odor after cleaning. R118's (4/14/26) physician wound assessment states per patient, he spends most of the day in his (wheelchair) and when not in the chair is lying on his back in bed. Patient states that he is not able to reposition himself. R118's Physician Order Sheets include (6/16/26) Sacrum: cleanse with wound cleanser, pat dry, skin prep, apply Vaseline gauze and cover with dry dressing PRN (as needed). Apply PRN dressing – if wound vac fails to maintain suction. (6/26/26) Sacrum: cleanse with wound cleanser, pat, apply skin prep to peri wound then adaptic to bone, black foam, and apply wound vac as directed at 125mmhg 3x/week Tuesday, Thursday, Saturday and PRN x 30 days. R118's care plan states (4/14/26) Resident has a stage 4 sacrum pressure ulcer related to immobility and incontinence, interventions: follow facility policies/protocols for the prevention/treatment of skin breakdown. Pressure reducing mattress on bed. Reposition resident every 2 hours. (5/13/26) Resident is on intravenous antibiotic medication related to sacral wound infection. (6/16/26) The resident has a sacral wound requiring wound vac therapy related to impaired skin integrity, interventions: Reposition resident at least every 2 hours and as tolerated to reduce pressure on sacral area. Maintain wound vac at prescribed settings and ensure continuous therapy as ordered by physician. Verify wound vac seal is intact and functioning properly each shift and as needed. R118's (5/5/26) physician wound assessment states (stage 4) sacrum pressure ulcer 8.0 x 5.7 x not measurable cm. Depth is unmeasurable due to presence of nonviable tissue and necrosis. Peri wound radius: odor. Exudate: heavy purulent. Thick adherent devitalized necrotic tissue: 100%. One or more signs of clinical infection. Surgical excisional debridement procedure: Devitalized tissue and necrotic muscle level tissue were removed at a depth of 2.7cm and healthy tissue was observed. Patient (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	requiring an increase in the level of care. Given decline in wound over 1 week with foul odor, and abscess extending almost to bone under necrosis, recommend patient go to emergency department for workup and treatment above scope of skilled nursing facility. The facility census affirms R118 was transferred to the hospital on 5/5/26 and returned to the facility on 5/11/26 (6 days later). R118's history and physical includes (5/26/26) Assessment/Plan: infected sacral wound systemic inflammatory response syndrome due to infected sacral ulcer. General surgery has been consulted. Will hold anticoagulation in anticipation of surgical debridement of the sacral wound. (5/10/26) The site is bleeding and has a lot of dark red tissue inside, it goes to the bone. The patient has a PICC (Peripherally Inserted Central Catheter) line and will receive antibiotics for six weeks. R118's (4/10/26) BIMS (Brief Interview Mental Status) determined a score of 10 (moderate impairment). On 6/29/26 at 9:56am, R118 was lying atop of a LALM (Low Air Loss Mattress) on his back at this time - the sacrum wound was not offloaded. Surveyor inquired how frequent R118's sacrum dressing is changed. R118 responded, I (R118) don't have no dressings however a wound vac canister (full of blood) was observed next his bed. On 6/29/26 at 10:03am, surveyor inquired about R118's sacrum wound treatment. V14 (LPN/Licensed Practical Nurse) stated, He (R118) has a wound vac. Surveyor inquired who administers facility wound care. V14 responded, It might be wound care, or wound management. V20 (Certified Nursing Assistant) affirmed that she (V20) was assigned to R118 and stated his (R118) incontinence brief was changed before breakfast however it contained a moderate amount of urine and diarrhea at this time. In addition, a dried brown ring was noted on the pad - beneath R118's buttocks. V20 turned R118 to inspect the brief and the wound vac continuously alarmed due to wound vac dressing not adhered to the skin (near the anus). Surveyor inquired about the brown substance covering R118's entire sacral dressing. V14 responded, BM (Bowel Movement) on his (R118) butt and it's here on the tape, it's a dressing. Surveyor inquired about the dried brown ring observed on R118's pad V20 replied, His (R118) wound leaks, it's his drainage from his wound. V14 advised that the wound care nurse would be contacted to change R118's dressing, proceeded to cover resident with the sheet and then left the room. On 6/29/26 at 10:27am, (24 minutes later) surveyor inquired why V14 (LPN) didn't change R118's sacrum dressing - which remained covered with BM. V14 stated, Because when they (facility) have a treatment nurse the treatment nurse does it, not me. On 6/20/26 at 10:33am, V15 (RN/Registered Nurse) approached surveyor and stated, I'm (V15) a floor Nurse, I'm not the wound Nurse. I (V15) was pulled to the floor to do the wounds around 9am. I don't usually do the wound care and affirmed that she (V15) was going to administer R118's sacrum treatment. Surveyor inquired about R118's treatment V15 responded His (R118) wound vac is Tuesday, Thursday, and Saturday. He (R118) gets PRN (as needed) wound cleanser, Vaseline gauze and cover with dry dressing. Surveyor requested that V15 review R118's treatment orders - prior to administration V15 subsequently reviewed the orders (with surveyor) and replied that the wound vac orders are also PRN and affirmed that she (V15) would not be administering R118's wound vac treatment at this time. Surveyor inquired why R118's wound vac would not be administered (as prescribed) V15 stated We (facility) have the wound nurse do the wound vac cause we (facility) have (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 7/2/26 at 11:44am, surveyor inquired about staff requirements for identified skin integrity impairments V4 (Medical Director) stated They (staff) need to notify the nursing staff and then the nursing staff will reach out to the providers and the wound care. The provider will then integrate care. Surveyor inquired if a resident has a sacrum skin integrity impairment what should be implemented to prevent further breakdown. V4 responded, We (facility) have a set of protocol that we follow, we need to address the nutritional aspect, change the position of the patient, notify the family, involve the wound care services, and see what they (wound care) are recommending. Surveyor inquired if a sacrum wound is not offloaded what's the potential outcome. V4 replied, Its gonna break down. Surveyor inquired what exudate odor is indicative of. V4 stated, It probably means that there is secondary infection of the wound. Surveyor inquired when staff should identify skin integrity impairments. V4 replied, As soon as possible, first of all they (residents) should not have any breakdown, as soon as staff identifies breakdown, they need to notify staff. Surveyor inquired about potential harm to residents if skin integrity impairments are not identified/reported. V4 stated, If we don't take care of it right away, is gonna escalate, turn into stage 4, get worse and can involve the muscles and the bone. R8's diagnoses include anoxic brain damage. R8's (6/10/26) functional assessment affirms the resident is dependent on staff for rolling left and right. R8's (6/4/26) care plan states the resident has impaired skin integrity related to pressure, decreased mobility, and cognitive impairment as evidenced by stage 3 pressure injury to right heel. R8's (6/10/26) BIMS determined that the resident is rarely/never understood. On 6/29/26 at 11:09am, R8 was lying in bed atop of a LALM set on 165 pounds (R8's 6/9/26 weight was 109 pounds – therefore incorrect setting) and static mode (static mode provides a firm surface). On 6/29/26 at 11:21am, V17 (Registered Nurse) affirmed that she's (V17) assigned to R8. Surveyor inquired about R8's LALM settings V17 stated She's (R8) at like 165. Surveyor inquired if 165 is the weight setting V17 responded No, that's just the setting it's on. I (V17) think she weighs a little less than that. Surveyor inquired what mode R8's LALM is on V17 replied It says that the static is on. Surveyor inquired what static mode indicates V17 stated I'm (V17) not really sure what that refers to and failed to adjust the LALM settings at this time. On 6/30/26 at 9:50am, surveyor inquired what static mode indicates on the LALM V3 (ADON) stated It's just static, its continuous - it doesn't alternate. Surveyor inquired what mode the LALM should be on when a resident is lying in bed asleep V3 responded We (staff) would want to have it on alternate, cause it can alternate the pressure for them (residents). Surveyor inquired what the numbers indicate on the LALM settings V3 replied It would be representative to the patients' weight. R90's Face sheet documents in part that R90 is a [AGE] year-old female admitted to the facility on [DATE]. Diagnoses include in part chronic respiratory failure, dependence on respirator (ventilator), type 2 diabetes, chronic pulmonary embolism, conversion disorder with seizures or convulsions, resistance to multiple antibiotics, and osteomyelitis. R90's Minimum Data Set (MDS) on 4/6/2026 documents in part that Staff Assessment for Mental (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Status is a 3 indicating that resident is severely cognitively impaired, and that R90 is dependent for all Activities of Daily Living (ADLs). On 6/30/2026 at 10:25AM, R90's low air loss mattress was set on Static Mode. V14 (Licensed Practical Nurse/LPN) states that I (V14) think we use the static button when residents have trach/ventilators so they are not moved too much. On 6/30/2026 at 11:23AM, V7 (Wound Licensed Practical Nurse) stated there is no reason to be on static mode due to having a trach/vent. The only time the static button should be on is if we are performing personal care or turning a resident so that they do not roll off the bed, and then the button should be turned off once the care is complete. R121's Face sheet documents in part that R121 is a [AGE] year-old male admitted to the facility on [DATE]. Diagnoses include in part Cerebral Infarction, dysphagia, hypertension, tracheostomy, epilepsy, and nontraumatic intracerebral hemorrhage. R121's Minimum Data Set (MDS) on 6/4/2026 documents in part that Staff Assessment for Mental Status is a 3 indicating that resident is severely cognitively impaired, and that R121 is dependent for all Activities of Daily Living (ADLs). On 6/29/2026 at 10:04AM, Surveyor noted that R121's left heel was offloaded from the mattress on pillows, while the right heel was laying directly on the mattress. V52 (Restorative Certified Nursing Assistant/CNA) confirmed this observation and noted that only one heel protector boot is here, I (V52) will look for the other one because he (R121) should have two. On 7/2/2026 at 12:49PM, R121's low air loss mattress was set to static mode. V3 (Assistant Director of Nursing) confirmed the setting and stated it should not be on static mode so that resident gets the benefit of the pressure relief mattress. R11's Face sheet documents in part that R11 is an [AGE] year-old male, admitted to the facility on [DATE]. Diagnoses include in part acute and chronic respiratory failure with hypoxia, dependence on respirator (ventilator), atherosclerotic heart disease, severe sepsis with septic shock, and benign prostatic hyperplasia. R11's Minimum Data Set (MDS) on 6/5/2026 documents in part that Staff Assessment for Mental Status is a 3 indicating that resident is severely cognitively impaired, and that R11 is dependent for all Activities of Daily Living (ADLs). On 6/29/2026 at 09:41AM, Surveyor observed R11 in bed. Adhesive foam dressings were noted on right forearm and left hand, both undated. Heel protector boots were on a table in the corner of the room; R11's heels were resting directly on the mattress. On 6/29/2026 at 01:25PM, V15 (Registered Nurse/RN) stated that she (V15) had changed the dressing on R11's left hand a little while ago but was unaware and did not assess the right arm for a wound. V15 (RN) states she (V15) will call wound doctor for orders after assessing what is under the dressing. R52's Face sheet documents in part that R52 is a [AGE] year-old female admitted to the facility on [DATE]. Diagnoses include in part acute respiratory failure with hypercapnia, dysphagia, dependence (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	on respirator (ventilator), pulmonary embolism, cardiac arrest, tracheostomy, hypertension, anxiety, obstructive sleep apnea and chronic kidney disease. R52's Minimum Data Set (MDS) on 5/23/2026 documents in part that Staff Assessment for Mental Status is a 3 indicating that resident is severely cognitively impaired, and that R52 is dependent for all Activities of Daily Living (ADLs). On 6/29/2026 at 10:14AM, Surveyor observed R52 laying in bed, regular mattress (no air loss mattress), with heels laying directly against the mattress. On 6/29/2026 at 10:54AM, V54 (daughter of R52) reported there have been issues with CNAs (Certified Nursing Assistants) checking on R52. V54 states that R52 had developed wounds from the pamper because it was put on too tight. V54 (daughter of R52) reports that it is better now because they are not using the pampers anymore. On 6/29/2026 at 1:30PM, Surveyor observed V15 (Registered Nurse) performing wound care to R52's gluteal/sacral area. Area of current breakdown correlates with the lower gluteal area where the diaper previously would lay against the skin. On 6/30/2026 at 10:15AM, V14 (Licensed Practical Nurse/LPN) that R52 affirmed that resident remains on a standard mattress, no offloading of heels nor specialty mattress for preventative measures. V14 (LPN) confirmed that R52 has wounds and remains high risk for wounds, and will follow up. R100's Face sheet documents in part that R100 is a [AGE] year-old male admitted to the facility on [DATE]. Diagnosis includes in part chronic respiratory failure, dependence on respirator (ventilator), end stage renal disease, dependence on dialysis, bacteremia, type 2 diabetes, epilepsy, vascular dementia, and pressure ulcers. R100's Minimum Data Set (MDS) on 4/30/2026 documents in part that Staff Assessment for Mental Status is a 3 indicating that resident is severely cognitively impaired, and that R100 is dependent for all Activities of Daily Living (ADLs). On 7/2/2026 at 01:04PM, Surveyor observed R100 in bed with only one heel protector on the left foot. Right foot was resting directly on the mattress. V3 (Assistant Director of Nursing) confirmed these findings and could not locate the other heel protector boot in the room. On 6/22/26 at 10:55am, during observation of residents in the Activity/Dining Room, R47 was observed sitting in the wheelchair without pressure relieving cushion/device. Again, at 11:45am, R47 was in the same position in the activity room. At this time, V24(Restorative Director) in the dining room was notified and V24 stated that she(V24) would get a cushion for R47's wheelchair. V47 added that the residents at risk for pressure ulcers should have cushions on wheelchairs to prevent pressure ulcers. On 6/22/26 at 10:15am and 12:45pm, during observation of residents on the unit, the following residents were observed on low air loss mattresses with the machine at the wrong weight settings: R12 weighs 191 pounds LALM weight setting was at 250 pounds. (continued on next page)

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(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 Note: The nursing home is disputing this citation.	R123 weighs 129 pounds LALM weight setting was at 250 pounds. R55 weighs 177 pounds LALM was not set at any weight. On 6/29/26 at 1:55pm, the surveyor showed all 3 residents' LALM to V15(RN/Wound Nurse). V15 stated that the LALM machine should be set to the nearest weight closest to the resident's weight. V15 explained that it could be that R55's LALM that was not on any weight setting was accidentally knocked off by someone's leg; V15 stated that she(V15) would work on all the LALMs and ensure that they are at the correct weight settings for each resident. R12's Records show the following: Face sheet shows diagnoses which include but are not limited to Dementia, Osteoarthritis of Hip, Disorders of Muscles and Low Back Pain. Pressure Ulcer Risk assessment dated [DATE] shows that R12 is at risk for more pressure ulcers. MDS (Minimum Data Status) section C (BIMS/Basic Interview for Mental Status) dated 6/5/26 for R12 shows a score of 6 out of 15(Severe Cognitive Impairment). MDS section M dated 6/5/26 states that R12 has unhealed stage 4 pressure ulcer and requires pressure reducing devices for chair and bed Care plan dated 2/13/26 states in part: R12 is at risk for alteration in skin integrity, has a sacral pressure injury, receiving Hospice services. Intervention states to provide Pressure relieving mattress, questions, and positioning devices as ordered. R123's Records show the following: Face sheet shows diagnoses which include but are not limited to Dementia, Hemiplegia and Hemiparesis, Pressure Ulcer Risk assessment dated [DATE] shows that R123 is at risk for more pressure ulcers. MDS (Minimum Data Status) section C (BIMS/Basic Interview for Mental Status) dated 3/20/26 for R123 shows a score of 00 out of 15(Severe Cognitive Impairment). MDS section M dated 3/20/26 states that R123 is at risk for pressure ulcers and requires pressure reducing devices for chair and bed. R47's Records show the following: Face sheet shows diagnoses which include but are not limited to Dementia, Alzheimer's Disease, Weakness, And Peripheral Vascular Disease. Pressure Ulcer Risk assessment dated [DATE] shows that R47 is at risk for more pressure ulcers. Care plan Intervention dated 3/3/26 states that R47 should have a pressure reducing cushion in chair. (continued on next page)

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	07/02/2026

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 Note: The nursing home is disputing this citation.	MDS (Minimum Data Status) section C (BIMS/Basic Interview for Mental Status) dated 5/26/26 for R47 shows a score of 6 out of 15(Severe Cognitive Impairment). MDS section M dated 5/27/26 states that R47 is at risk for pressure ulcers and requires pressure reducing devices for chair and bed. R55's Records show the following: R55 stated that she(R55) came to the facility without any pressure ulcers but now has had pressure ulcers two times. Face sheet shows diagnoses which include but are not limited To Weakness, Muscle Wasting and Atrophy, Poorly Neuropathy, Abnormalities of Gait and Mobility, Peripheral Vascular Disease, Type 2 Diabetes, And Disorder of Muscle. Pressure Ulcer Risk assessment dated [DATE] shows that R55 is at risk for more pressure ulcers. Care plan Intervention dated 2/17/25 states that R55 should have a pressure reducing mattress on bed. MDS (Minimum Data Status) section C (BIMS/Basic Interview for Mental Status) dated 5/26/26 for R47 shows a score of 6 out of 15(Severe Cognitive Impairment). MDS section M dated 4/7/26 states that R55 is at risk for pressure ulcers and requires pressure reducing devices for chair and bed. Facility policy Pressure Ulcer Prevention (6/2026) documents in part that All residents will receive timely, individualized risk assessments, appropriate preventative interventions, and ongoing monitoring to ensure skin integrity is preserved to the greatest extent possible and that Skin will be monitored and early changes in skin integrity will be addressed by the licensed nurse. The pressure injury prevention policy (revised 6/2026) states this skilled nursing facility maintains and implements a comprehensive pressure injury prevention program designed to reduce incident, severity, and recurrence of pressure injuries. All residents will receive timely, individualized risk assessments; appropriate preventive interventions; and ongoing monitoring to ensure skin integrity is preserved to the greatest extent possible. All beds in the facility will have pressure reducing mattresses unless pressure relieving, or specialty support surface mattresses are required according to the resident's needs. Interventions to maintain skin integrity or to promote healing will be incorporated into the plan of care based on each resident's individual needs and risks. Interventions will address as appropriate: repositioning and mobility, support surfaces. The medical provider is notified of changes in skin integrity and treatment orders are obtained and implemented. The (undated) alternating and low air loss pressure relief system policy states the caregiver can select the static function to stop alternating function.