

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000467	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/26/2017
--	--	--	---

NAME OF PROVIDER OR SUPPLIER GENERATIONS AT APPLEWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 21020 KOSTNER AVENUE MATTESON, IL 60443
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1010h) 300.1210b) 300.1210d)5) 300.3240a) Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following	S9999	<p>Attachment A Statement of Licensure Violations</p>	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE 06/13/17
---	-------	------------------------------

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000467	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/26/2017
--	--	--	---

NAME OF PROVIDER OR SUPPLIER GENERATIONS AT APPLEWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 21020 KOSTNER AVENUE MATTESON, IL 60443
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 1</p> <p>and shall be practiced on a 24-hour, seven-day-a-week basis:</p> <p>5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.</p> <p>Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These Requirements are not met as evidenced by:</p> <p>Based on observation, interview, and record review the facility failed to prevent, identify and treat pressure ulcers for one resident (R12) of two residents reviewed for pressure ulcers in the sample of 18. This failure resulted in R12 developing multiple deep tissue injuries to the left lower leg and right foot.</p> <p>Findings include:</p> <p>The facility's, undated, Pressure Ulcer Prevention Protocol, documents "4. Residents who are assessed as being at High Risk will have a plan of care that will include: A. Daily skin checks conducted by either the CNA or Licensed Nurse to ensure early identification of potential problem areas. B. Plan of Care to address mobility status and ability to reposition self. C. Use of Pressure</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000467	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/26/2017
--	--	--	---

NAME OF PROVIDER OR SUPPLIER GENERATIONS AT APPLEWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 21020 KOSTNER AVENUE MATTESON, IL 60443
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 2</p> <p>Reducing Devices, such as pressure reducing mattresses, mattress overlays, w/c (wheel chair) cushioning devices, if needed. D. Determination of need for supplemental skin care such as barrier cream or moisturizing lotion. E. Any other factor identified on the risk assessment including but not limited to nutritional support, positioning/support devices, or medication review."</p> <p>The Physician's Order Report, dated 5/24/17, documents a preventative "hydrocolloid dressing" for R12's sacrum but does not include any wound treatments or any other pressure ulcer preventative measures for R12.</p> <p>The Medication Administration History for R12, dated 5/1/17 through 5/24/17 documents "Skin assessment twice weekly on shower days" on "3-11pm on Wednesday" and "7:30am - 3:30 pm on Saturday." This form documents that in May 2017, R12's skin was assessed on the following six days; 5/3/17, 5/6/17, 5/10/17, 5/13/17, 5/17/17, and 5/20/17 with either "no findings" or "old findings."</p> <p>R12's Current Care Plan, dated 5/24/17, documents Problem as "(R12) is at risk for skin breakdown R/T (related to) Dementia and incontinence and HX (history) of cellulitis and HX of closed pressure areas." This Care Plan also documents an approach to "Assess resident for presence of risk factors. Treat, reduce, eliminate risk factors to extent possible." "Report any signs of skin breakdown (sore, tender, red, or broken areas)." This Care Plan documents the Goal as "(R12's) skin will remain intact thru next review.</p> <p>The Braden Scale (pressure ulcer risk assessment), dated 4/7/17 documents R12 as a</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000467	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/26/2017
--	--	--	---

NAME OF PROVIDER OR SUPPLIER GENERATIONS AT APPLEWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 21020 KOSTNER AVENUE MATTESON, IL 60443
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 3</p> <p>"High Risk" for skin breakdown.</p> <p>The Quarterly MDS (Minimum Data Set) for R12, dated 4/10/17, documents "yes" in Section M0150 that R12 is at risk of developing pressure ulcers.</p> <p>The Wound Care Specialist Evaluation for R12, dated 4/26/17, documented by Z3 Facility Wound Doctor, documents R12's left sacral wound "Resolved on 4/26/17" with no other wounds identified.</p> <p>The Resident Progress Notes for R12, dated 5/3/17 through 5/23/17, do not include any documentation of R12 having any pressure ulcers.</p> <p>On 5/24/17 at 9:40am, 10:30am, 12:00pm, 1:00pm, 2:00pm, and 2:15pm, R12 was positioned lying in bed on (R12's) right side. At no time did R12 have any pressure reducing interventions present to bilateral feet or legs.</p> <p>On 5/24/17 at 9:40am, E16 and E20 CNA's (Certified Nursing Assistants) provided care for R12. During cares, R12 hollered out as E16 and E20 removed (R12's) bed sheet and pulled R12 up in the bed. E16 pulled R12's right and left legs apart at which time a deep reddish purple fluid filled blister was noted to R12's left inner leg. R12 hollered out again as E20 was applying a sock to R12's right foot where there was a dark reddish purple fluid filled blister to R12's right lateral bunion area, a large oval shaped clear fluid filled blister to R12's right lateral foot, and a dark reddish purple fluid filled blister to R12's right lateral heel. E16 and E20 CNA's turned R12 to R12's right side and exited R12's room.</p> <p>On 5/24/17 at 9:45am, E16 CNA stated R12's left</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000467	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/26/2017
--	--	---	---

NAME OF PROVIDER OR SUPPLIER GENERATIONS AT APPLEWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 21020 KOSTNER AVENUE MATTESON, IL 60443
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 4</p> <p>leg wound and right foot wounds have been there awhile, "at least the two months" that (E16) has been working at the facility. E16 stated she did not report R12's wounds to anyone because they are not new. E16 also stated E20 CNA is new and is in orientation so (E20) would not have reported it.</p> <p>On 5/24/17 at 2:15pm, E5 LPN (Licensed Practical Nurse) stated R12 only had a sacral wound and is unaware of any other wounds to R12 and no one has reported any new wounds.</p> <p>On 5/24/17 at 2:45pm, E2 DON (Director of Nursing) stated she is unaware of any wounds to R12 other than R12's resolved sacral wound.</p> <p>On 5/24/17 at 10:05 am, E17 Wound Nurse stated pressure ulcers are assessed weekly and skin assessments are done twice a week on shower days for high risk residents. E17 stated R12's sacral wound has closed, R12 remains a high risk for pressure ulcers, R12 should be turned and repositioned every two hours, have boots on and pillows used for positioning. E17 also stated she is unaware of R12 having any other pressure ulcers and no one has reported any.</p> <p>On 5/24/17 at 3:00 pm, E2 DON (Director of Nursing) and E17 Wound Nurse performed a skin check of R12's body, acknowledged the new wounds to R12's left inner leg, and R12's right foot with the following measurements: dark reddened area to left inner leg measuring 3.0cm (centimeters) x 0.7cm x 0.2 cm; DTI (deep tissue injury) to right lateral foot measuring at 3.0cm x 2.5cm x DTI; Fluid filled blister to right medial foot measuring 4.0cm x 3.0cm and Fluid filled blister to right to right lateral heel measuring 5.0cm x</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000467	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/26/2017
--	--	---	---

NAME OF PROVIDER OR SUPPLIER GENERATIONS AT APPLEWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 21020 KOSTNER AVENUE MATTESON, IL 60443
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 5</p> <p>4.0cm.</p> <p>On 5/25/17 at 10:52 am, Z3 Facility Wound Doctor stated she is familiar with R12, stated R12 is a high risk for developing pressure ulcers, she would expect the staff to turn and reposition R12 every two hours, provide R12 with off-loading and support for pressure areas. Z3 also stated she has not seen R12 for a few weeks and was not aware of any other wounds on R12.</p> <p>(B)</p> <p>300.670k)1)</p> <p>Section 300.670 Disaster Preparedness</p> <p>k) Coordination with Local Authorities</p> <p>1) Annually, each facility shall forward copies of all disaster policies and plans required under this Section to the local health authority and local emergency management agency having jurisdiction.</p> <p>This requirement is not met as evidenced by:</p> <p>Based on record review and interview the facility failed to annually forward copies of the facility's disaster policies and plans to the local health authority and local emergency management agency. These failures have the potential to affect all 89 residents residing in the facility.</p> <p>Findings include:</p> <p>On 5/23/17, the facility's Life Safety Manual did</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000467	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/26/2017
--	--	--	---

NAME OF PROVIDER OR SUPPLIER GENERATIONS AT APPLEWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 21020 KOSTNER AVENUE MATTESON, IL 60443
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 6</p> <p>not contain evidence that the facility submitted their disaster plan, policies and procedures to the local health authority or local emergency management agency within the last year (4/2016-5/2017).</p> <p>On 5/24/17 at 10:15 AM, E12 (Vice President of Physical Plant and Dietary Operations) verified that the facility did not have documentation that they had sent their disaster policies and procedures to the local health authority or local emergency management agency within the last year.</p> <p>The Resident Census and Conditions of Residents (Centers for Medicare and Medicaid-672) form dated 5/23/17 and signed by E8 (Minimum Data Set Coordinator) documents that there are currently 89 residents residing in the facility.</p> <p>(No Violation Issued)</p>	S9999		
-------	---	-------	--	--