

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0049841		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/26/2026	
NAME OF PROVIDER OR SUPPLIER GENERATIONS AT REGENCY				STREET ADDRESS, CITY, STATE, ZIP CODE 6631 MILWAUKEE AVENUE , NILES, Illinois, 60714			
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S0000	Initial Comments		S0000			04/10/2026	
	Annual Re-Licensure and Recertification Survey.						
S9999	Final Observations		S9999			04/10/2026	
	Statement of Licensure Violations:						
	300.610a)						
	300.1210b)						
	300.1210d)5						
	Section 300.610 Resident Care Policies						
	a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility.						
	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 and shall be practiced on a 24-hour, seven-day-a-week basis:						
	5) A regular program to prevent and treat pressure						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 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. These regulations were not met as evidence by: Based on observation, interview, and record review, the facility failed to ensure that 2 of 4 residents (R8, R98) who entered the facility without pressure ulcers received the necessary treatment and services to prevent the development of new pressure ulcers and to promote the healing of existing ulcers. Specifically, the facility failed to implement mandatory pressure-redistribution protocols and provide timely incontinence care for a ventilator-dependent resident (R8) and a quadriplegic resident (R98). This failure to provide essential clinical services resulted in the development of a facility-acquired Stage 4 sacral pressure ulcer for R8 that was observed to be actively hemorrhaging, and a facility-acquired unstageable pressure ulcer for R98, who was found in a prolonged soiled state. The findings include: R98 is a 94-year-old quadriplegic with a facility-acquired unstageable right gluteus pressure ulcer. Observation of Discomfort (03/23/2026): At 10:47 AM, R98 informed two surveyors he was "uncomfortable" and requested to be "moved up in bed." LPN V10 was unable to identify the assigned CNA (V12), who had not yet provided care or repositioning as of 11:00 AM. Observation of Prolonged Neglect (03/24/2026): At 11:30 AM, two surveyors requested to observe R98's wound. As V10 (LPN) and V21 (CNA) repositioned the resident—who again requested help for repositioning due to discomfort—surveyors observed the resident in a heavily wet incontinence brief. The moisture had saturated through the resident's linens and onto the air mattress. Surveyors observed a visible yellowish circle of wetness with a darkened yellow circumference ring.			S9999			04/10/2026

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S9999	Continued from page 2 Clinical Significance: The presence of a "darkened circumference ring" indicates that the urine had remained on the linens long enough for evaporation and concentration to occur, proving a prolonged lapse in hygiene care. This exposure to moisture and caustic body fluids directly compromised the integrity of the skin and the healing potential of the resident's unstageable wound. Clinical Impact: The facility's failure to provide a fixed, mandatory turning and toileting schedule resulted in the resident's facility-acquired unstageable wound being exposed to prolonged moisture and friction, directly impeding the healing process and causing documented resident distress. (R8): Failure to Implement Treatment for Stage 4 Wound R8 is a 60-year-old, non-verbal, ventilator-dependent resident with a facility-acquired Stage 4 sacral pressure ulcer (6.4 cm x 10.6 cm). Observation of Hemorrhage (03/24/2026): At 9:50 AM, during a dressing change, the sacral wound (the size of a tennis ball) was observed with 20% slough and active bleeding. The resident's dressing and incontinent pad were saturated with blood. Failure to Implement Physician Orders: Despite a Nurse Practitioner (NP) order on 03/23/26 to "turn every two hours," the facility failed to execute this treatment. On 03/25/2026, R8 was observed lying in a continuous supine position—directly on the hemorrhaging Stage 4 wound—from 9:50 AM to 12:05 PM (2 hours and 15 minutes) without any staff intervention. On 03/25/2026, the Director of Nursing (V2) stated that "Staff should turn and reposition every two hours." However, clinical observations proved this was not occurring. Staff Admissions: LPN V10's inability to identify staff assignments and the discovery of R98 in a state of "dried-ring" incontinence moisture confirm that the facility lacked a functioning system for monitoring and delivering pressure ulcer care. Care Plan Deficiency: The facility utilized discretionary language in the care plans ("May reposition") which allowed staff to bypass the NP's mandatory 2-hour turning order and basic hygiene requirements. The facility's failure to provide the "necessary treatment and services" required by F686 resulted in			S9999			04/10/2026

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S9999	Continued from page 3 the two facility-acquired pressure ulcers. The facility allowed a quadriplegic resident to remain in a soiled state for a duration long enough to saturate an air mattress and create dried rings of urine on the linens, while simultaneously failing to reposition a ventilator-dependent resident with an actively bleeding Stage 4 wound. This lack of clinical intervention directly led to the development and worsening of life-threatening deep tissue injuries. Surveyors were unable to obtain an interview with V39 Wound doctor after multiple attempts and calling on 3/25/26 at 5:15 PM and again on 3/26/26 at 10:20 AM and 4:50 PM. R8 is a 60-year-old, male originally admitted in the facility on 07/15/23 with the following diagnoses: Anoxic Brain Damage, Not Elsewhere Classified; Chronic Respiratory Failure with Hypoxia; Encounter for Attention to Tracheostomy; Encounter for Attention to Gastrostomy; and Dependence on Respirator (Ventilator) Status. MDS (Minimum Data Set) dated 08/08/25 documented R8 has short- and long-term memory problems; with cognitive skills for daily decision making severely impaired. MDS (Minimum Data Set) dated 02/05/26 documented R8 has one unhealed pressure ulcer/injuries. On 03/23/26 at 11:05 AM, R8 was observed in bed; nonverbal, opens eyes but unable to follow commands and instructions, unable to move self. R8 is bedbound, with ongoing tube feeding of Glucerna at 70 ml/hr (milliliters per hour). R8 has tracheostomy tube connected to ventilator for respiration. R8's Wound Evaluation and Management Summary dated 03/20/26 documented: Stage 4 pressure wound on the sacrum, measurements 6.4 cm x 10.6 cm x 0.5 cm. R8's POS (Physician Order Sheet) recorded: 03/20/26 - Sacrum: cleanse with NSS (normal saline solution)/apply Dakin's soaked gauze/cover with DPD (dry protective dressing) daily for 30 days every day shift every Saturday Sunday for pressure ulcer for 30 days. 03/20/26 - Sacrum: cleanse with NSS/apply Dakin's soaked gauze/cover with DPD daily for 30 days every day shift every Monday Tuesday Wednesday Thursday Friday for pressure ulcer for 30 days.			S9999		04/10/2026	

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S9999	Continued from page 4 On 03/24/26 at 9:50 AM, wound care was observed performed by V8 (Wound Care Coordinator). R8's pressure wound on the sacral area is approximately the size of a tennis ball, appearing red, with 20% slough; bleeding was noted. R8's wound dressing and incontinent pad were saturated with blood. Despite the active hemorrhage and the NP's order, R8 was observed lying in a continuous supine position—placing direct, unrelieved pressure on the bleeding Stage 4 wound—from 9:50 AM to 12:05 PM (2 hours and 15 minutes). No staff entered the room to perform the required repositioning during this period. R8's care plan recorded: Has potential for further skin breakdown/pressure ulcer/diabetic ulcer due to immobility, bowel incontinence dated 03/01/26: Interventions: Follow facility protocols for treatment of injury. May reposition every 2 hours as needed NP (Nurse Practitioner) progress notes dated 03/23/26 documented in part: turn every two hours. On 03/25/26 at 9:50 AM, random observation conducted every 15 minutes over a two-hour period revealed R8 was not repositioned. From 9:50 AM to 12:05 PM, he was observed in bed, in a supine position. On 03/25/25 10:30 AM, V36 (Registered Nurse, RN) was asked regarding interventions in management of pressure ulcers. V36 stated residents with pressure ulcers should be turned and repositioned every two hours. V27 (RN) and V38 (Certified Nurse Assistant, CNA) also stated residents are turned every two hours. V27 verbalized R8 should be turned and repositioned every two hours. On 03/25/2026 at 12:28 PM, V8 was interviewed regarding R8. V8 replied, "R8 has sacral pressure ulcer Stage 4, a facility acquired. It was identified on 11/24/25 as Unstageable. He needs to be turned and repositioned every two hours and as needed. On 03/25/2026 at 2:55 PM V2, (Director of Nursing) was asked regarding pressure ulcers. V2 stated, "Staff should turn and reposition every two hours			S9999			04/10/2026

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S9999	Continued from page 5 and as needed. Facility's policy titled "Pressure Ulcer Prevention Protocol" dated 05/18 stated in part but not limited to the following: Procedure: 4. Intervention necessary to maintain skin integrity or to promote healing will be incorporated in to the plan of care based on each resident's individual needs and risks, which may include: E. Any other factor identified on the risk assessment including but not limited to nutritional support, positioning/support devices, or medication review. 5. The resident's care plan will indicate the resident's risk factor (s) and include individualized interventions as needed for a comprehensive pressure ulcer prevention program. (A)			S9999			04/10/2026