STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145852	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Vista Prospect Heights	700 East Euclid Avenue Prospect Heights, IL 60070

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	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure ongoing monitoring, assessment to identify worsening of skin impairment and notify the physician for appropriate treatment in a timely manner. This failure resulted in R11's Moisture Associated Skin Disorder (MASD) on left buttocks to progress to sacral/coccyx area stage 3 pressure ulcer with slough formation. This deficiency affects one (R11) of one resident in the sample of 9 reviewed for Wound Care Management. Findings include: On 12/9/25 at 11:36AM, Observed V15 CNA (Certified Nurse Assistant) and V16 CNA repositioned R11 to her left side for wound care. Observed open wound on sacrococcygeal area without dressing exposed to disposable adult brief soiled with urine. V16 said that she provided incontinence care to R11 this morning at around 7:00am and her wound dressing fell off. She forgot to inform the V17 RN (Registered Nurse) and V3 Assistant DON (ADON)/Wound Care Coordinator (WCC). V3 said that V16 CNA should notify her or the floor nurse this morning when R11's wound dressing fell off. The open wound should be covered to prevent infection and enhance healing. V3 provided wound care to R11. V3 said that R11's wound deteriorated from left buttocks MASD (Moisture Associated Skin Disorder) to pressure ulcer on sacrococcygeal area with 80% slough formation and 20% reddish tissue with serosanguinous drainage. V3 measured wound and obtained 1.5cm x 1cm x 0.1cm. V3 said that R11's wound worsens from last week when she saw her with V19 Wound Care Physician during wound rounds. V3 is not aware of this deterioration or worsening until today. V3 said that R11 wound treatment is being done by floor nurses, she only sees R11 during wound rounds as needed. V3 applied same treatment ordered for MASD, Zinc oxide and xeroform gauze covered with dry dressing. On 12/9/25 at 11:54AM, Surveyor asked V3 ADON/WCC if the treatment she applied for R11's deteriorated wound on sacrococcygeal is an appropriate treatment. V3 said that the treatment she applied is for MASD and is not appropriate treatment for open wound with slough formation. She said that she applied it for now until she received ordered from the physician.On 12/9/25 at 12:01PM, Informed V2 DON (Director of Nursing) of above concerns and requested for policies. On 12/9/25 at 1:17PM, Telephone interviewed with V18 RN (Registered Nurse). She said that she is the regular night shift nurse who took care of R11 on 10pm to 6am shift. She said that she provides treatment with zinc oxide cream and xeroform dressing on R11's left buttock MASD. The left buttock is dry, healed, skin intact and no open wound. She is not aware and did not see the pressure ulcer /open wound on sacrococcygeal area. She is aware that any skin changes or skin deterioration should be documented and notify the physician for appropriate treatment orders. On 12/9/25 at 2:05PM, V17 RN said that she is the regular morning shift (6am to 2pm) nurse who took care of R11 yesterday. She said that R11 has open wound in between her buttocks, sacrococcygeal area, with irregular wound edges, pinkish wound tissue, serosanguineous drainage, estimated quarter in size, it was from previous wound that re-open, but she cannot remember when. She has been applying zinc oxide, xeroform and covered with bordered dressing. On 12/9/25 at 3:05PM, Reviewed R11's medical records with V2 DON. R11 is admitted on [DATE] with diagnosis listed in part but not limited to History of falling, displaced Tri malleolar fracture of left lower leg, Closed fracture with routine healing, Subluxation of left ankle joint, Muscle weakness, Muscle wasting, Unsteadiness on feet and hearing loss. Active (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0686 Level of Harm - Actual harm Residents Affected - Few	Physician order sheet indicated: Apply to Left buttocks Zinc oxide external paste 20% topically and xeroform then cover with dry dressing after cleaning with normal saline (NS) every shift and as needed for wound care (ordered 11/19/25). Apply to left buttocks Calcium alginate silver external pad 4x 8 topically after cleansing with NS one time a day, and every 8 hours as needed for wound care ordered 12/9/25 after surveyor observed the open wound/ pressure ulcer. Most recent Braden scale assessment for predicting pressure sore risk done on 11/3/25 indicated severe risk for skin impairment. Comprehensive care plan indicated: R11 has a pressure ulcer and has potential for further skin impairment related to fragile skin, impaired/limited mobility, and incontinence/exposure to moisture. Left buttocks MASD. Most recent wound assessment done by V19 Wound Care Physician on 12/3/25 indicated: Non pressure wound of the left buttocks partial thickness/ MASD, healing good, measures 1.58cm x 1.06cm x 0.1cm, light serous exudate open areas with exposed dermis. V3 WCC documented in R11's progress notes after surveyor wound observation indicated: Skin issues notes: During dressing change, R11 was observed with deteriorating left buttocks with increase surface to coccyx/sacral area. Informed V2 of concerns in wound care management to ensure ongoing monitoring assessment and coordination of care to identify worsening of skin impairment and notify the physician for appropriate treatment in a timely manner. The accurate identification of wound site so there is no confusion or discrepancy in wound treatment. Writing of treatment orders on the same site for different etiology. On 12/10/25 at 10:04AM, Observed R11's sacrococcygeal pressure ulcer with V2 DON and V3 ADON/WCC. V2 said that there is no skin impairment on left buttock. There is pressure ulcer with slough formation on left sacrococcygeal area. On 12/11/25 at 10:12AM, Telephone interview with V19 Wound Care Physician (WCP). He said that R11's MASD on left buttocks deteriorated to Stage 3 pressure ulcer on sacrococcygeal area. After wound debridement, 10% thick necrotic tissue, 20% sough and 70 granulation tissue. Reviewed V19 WCP wound report and informed of the discrepancy and inconsistency from observation made yesterday pertaining to the wound location. V19 said that he will update and send his report. V19 Wound Care Physician updated progress notes dated 12/10/25 for R11's wound report indicated: Wound originally at left buttock but has localized to sacral/coccyx area. Will change location to sacrum/coccyx. Facility's policy on Pressure Injury Prevention and Wound Care Management revised 8/25/25 indicated: Purpose: to provide health staff with the standards of care and processes to be followed for all residents: *To identify factors that places the residents at risks for the development of pressure injuries and to implement appropriate interventions to prevent the development of clinically avoidable wounds.*To promote a systematic approach and monitoring process for the care of residents with existing wounds and for those who are at risk for skin breakdown.*To promote healing of existing pressure injuries and wounds.Policy: *It is the policy of this facility that each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing, in accordance with the comprehensive assessment and plan of care. * The facility will ensure that a resident who is admitted without a pressure injury does not develop a pressure injury, unless unavoidable*A resident who has pressure injury will receive care and services to promote healing and to prevent additional ulcers. Procedure:5. Resident's skin will be monitored daily during cares by nursing assistant and skin check will be completed weekly by licensed nurse. 6. Residents at risk for the development of pressure injury will have their individualized care interventions and approaches documented in the resident care plan.7. Skin impairmentsa. Weekly documentation will include pertinent characteristic of existing ulcers, including location, size, depth, maceration, color of the ulcer and surrounding tissues and description of any drainage, eschar, necrosis, odor, tunnelling, or undermining. 11. Daily, the clinicians responsible for caring for the resident will assess the status of dressing if present and evaluate for complications such as infection and or uncontrolled pain14. Wound and skin care interventions will be monitored and evaluated for effectiveness. Care plans will include specific and measurable goals and interventions. The care plan will be reviewed and revised at least quarterly or with significant change in condition. Prevention and Treatment Guidelines: 4. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Wounds will be treated based on etiology of the wound.10. Nursing staff should update the attending physician immediately of wounds that have developed complications and or not healing as anticipated. Facility's policy on Physician orders revision date 11/13/24 indicated: Purpose: To provide guidance to ensure physician orders are transcribed and implemented in accordance with professional standards.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview and record review the facility failed to provide timely oral care for one of three (R6) dependent residents reviewed for oral care in a sample of nine.Findings Include:On 12/9/2025 at 11:05am R6 was observed in bed with a foul mouth odor.On 12/9/2025 at 11:10am V16 (Certified Nursing Assistant-CNA) said I did oral care for R6 her mouth has an odor.On 12/9/2025 at 11:20am V2(Director of Nursing-DON), said I expect the nursing assistants to perform mouth care daily and as needed. An admission record dated 12/10/2025 indicates that R6 has an diagnosis of Hemiplegia and Hemiparesis following nontraumatic subarachnoid hemorrhage affecting left dominant side, dysphagia, oropharyngeal phase, GERD, and gastrostomy status, a order summary report dated 12/10/2025 that indicates NPO diet for failed speech swallowing dated 7/17/2023, a care plan dated 4/17/2024 with a focus of ADL self-care performance deficit impaired mobility, impaired cognition, hemiplegia left side a interventions for personal hygiene/oral care assist-one with grooming, oral hygiene-oral care every shift and often if needed.Facility Policy: Issue Date 3/15/2021 Activities of Daily Living (ADLs)Policy:Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable.Procedure.1. A resident will be given the appropriate treatment and services to maintain or improve is or her ability to carry out the activities of daily living.2. The facility will provide care and services for the following activities of daily living:3. Hygiene-bathing, dressing, grooming and oral care

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F 0684 Level of Harm - Minimal harm or potential for 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 observation the facility failed to apply ace wrap bandage to resident's bilateral lower extremities for edema as ordered by physician. The facility also failed to develop plan of care in managing resident's edema. This deficiency affects one (R11) of one resident in the sample of 9 reviewed for Quality of care.Findings include: On 12/9/25 at 11:26AM, Observed R11 with swollen bilateral lower extremities with V17 RN (Registered Nurse). V17 assessed R11's bilateral lower extremities for pitting edema. V17 said that she has bilateral pitting edema but more prominent on left lower leg. R11 is alert and responsive with periods of confusion. She has impaired hearing and slurred speech. On 12/9/25 at 3:05PM, Reviewed R11's medical records with V2 DON (Director of Nursing). R11 is admitted on [DATE] with diagnosis listed in part but not limited to Essential hypertension, Atrial Fibrillation, History of falling, Muscle weakness, Muscle wasting, Unsteadiness on feet and hearing loss. Active Physician order sheet indicated: Apply ace wrap to bilateral lower extremities (BLL) two times a day for edema to BLL, apply in AM and remove in PM. Comprehensive care plan did not address managing of edema using ace wrap bandage. Informed V2 of above concerns. V2 said that they should be following physician order and address resident's BLL edema in care plan. Surveyor requested for policy in Edema management and Application of ace wrap bandage. On 12/10/25 at 11:44AM, V2 DON said that they don't have policy/procedure guidance in Edema management and application of ace wrap bandage to BLL for edema. Facility unable to provide policy and procedure in Edema management and application of ace wrap bandage to BLL for edema. Facility's policy on Physician orders revision date 11/13/24 indicated: Purpose: To provide guidance to ensure physician orders are transcribed and implemented in accordance with professional standards. Facility's policy on Care Plan Baseline and comprehensive revision date 7/18/24 indicated: Policy: The interdisciplinary team will develop an individualized, comprehensive care plan for each resident based on their medical condition, medical history, assessment from different members of the interdisciplinary team, lifestyle, and current resident goals.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to follow physician order and implement care plan intervention for resident with limited mobility on left arm. This deficiency affects one (R3) of one resident in the sample of 9 reviewed for Limited mobility. Findings include: On 12/9/25 at 11:15AM, Observed R3 in Broda (Recliner chair) in the activity room leaning to right side off the recliner chair in front of V14 Activity Aide. No hand splint or wheelchair resting hand splint applied. Showed observation to V2 Director of Nursing (DON). V2 repositioned R3 in upright position. R3 is re-admitted on [DATE] with diagnosis listed in part but not limited to Senile degeneration of brain, Hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, Abnormal posture. Active physician orders indicated Apply functional hand splint to left hand, may remove for hygiene, skin checks and as per patient's tolerance. Wheelchair arm through the left side to facilitate proper positioning in wheelchair while up in wheelchair every day and evening shift for left side weakness. Comprehensive care plan indicated: She has an ADLs self-care performance deficit related impaired mobility, generalized weakness, hemiplegia. Interventions: AFO on LLE while up. LUE sing and hand splint while up and during transfers, left elevate arm trough- observe skin with AM/PM cares for redness, rash, swelling, open areas, pain, or other skin problems. R11's MDS assessment dated [DATE] Section GG0115 Functional Range of motion coded 1 (impairment on one side) Upper extremity (Shoulder, elbow, wrist, hand) and 1 (impairment on one side) Lower extremity (Hip, knee, ankle, foot). R11's occupational therapy Discharge summary dated [DATE] indicated recommend assist with all ADLs and functional transfers, L arm trough, L resting hand splint. On 12/9/25 at 2:05PM, V17 RN (Registered Nurse) said that they did not apply R3's left hand splint and wheelchair resting arm.On 12/9/25 at 2:13PM, V11 Occupational Therapist (OT) said that they recommended left hand splint and left arm trough to prevent contractures due to limited mobility. On 12/9/25 at 3:05PM, Both V1 Administrator and V2 DON said that they don't have Restorative program. Informed of above concern regarding not following physician order and implementing care plan intervention of left-hand splint application and wheelchair arm trough. On 12/11/25 at 9:52AM, Both V1 Administrator and V2 DON said that they don't have policy to prevent contractures for resident who has limited mobility. Facility does not have policy on Restorative program.Facility's policy on Orthotics issued on 12/8/25 indicated: Purpose: To ensure safe, clinically appropriate, person centered use of hand splints and braces that support function, prevent/mitigate contracture, or deformity, protect healing tissues, and reduce pain while maintaining resident rights, dignity, and freedom from unnecessary restraints.Scope: This policy covers prefabricated and custom hand/wrist/finger orthoses (e.g., resting hand splint). It applies across all shifts and settings in the facility. Procedure: 1. Indications: *Prevention management of contractures or spasticity2. Orders:*A provider order is required for an orthotic device*OT/PT evaluation will include clinical rationale, fit, education plan and or monitoring scheduleFacility's policy on Physician orders revision date 11/13/24 indicated: Purpose: To provide guidance to ensure physician orders are transcribed and implemented in accordance with professional standards. Facility's policy on Care Plan Baselined and comprehensive revision date 7/18/24 indicated: Policy: The interdisciplinary team will develop an individualized, comprehensive care plan for each resident based on their medical condition, medical history, assessment from different members of the interdisciplinary team, lifestyle, and current resident goals.

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F 0689 Level of Harm - Minimal harm or potential for 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 observation, interview, and record review the facility failed to implement fall prevention intervention to resident who has history of multiple falls. This deficiency affects one (R11) of one resident in the sample of 9 reviewed for Fall prevention program. Findings include: On 12/9/25 at 11:06AM, Observed R11 sitting in wheelchair in her room. She is alert with impaired hearing and slurred speech. The call light is away from her, unable to reach. Showed observation to V2 DON (Director of Nursing). V2 said that call light should be accessible and placed within resident reach for safety.On 12/9/25 at 3:05PM, Reviewed R11's medical records with V2 DON. R11 is admitted on [DATE] with diagnosis listed in part but not limited to History of falling, displaced Tri malleolar fracture of left lower leg, Closed fracture with routine healing, Subluxation of left ankle joint, Muscle weakness, Muscle wasting, Unsteadiness on feet and hearing loss. Care plan intervention indicated: Assist resident to meet needs and maintain safety; keep call light within reach, keep personal effects in easy reach. Comprehensive care plan indicated she is at risk for falls related to history of falls and weakness. R11's most recent fall assessment dated [DATE] indicated she is high risk for falling. R11's most recent unwitnessed fall dated 11/28/25 and witnessed fall on 11/26/25. Incident report on 11/26/25, indicated the nurse observed R11 sliding down from wheelchair She was lowered to the floor. R11 said that she was leaning forward to pick up the tissue. Root cause of fall completed. Incident report on 11/28/25 indicated R11 was found on the floor in her room. She said she did not know how she fell on the floor. She was sent to the hospital for evaluation. Root cause of fall completed just copy from the previous incident report dated 11/26/25. R11's Physician progress notes dated 12/8/25 listed in part but not limited to indicated: 2. Fall on 11/28/25 status post ER evaluation with no new injuries sustained: See plan as above. We will monitor patient closely. 5. Mechanical fall resulting in left ankle fracture/bimalleolar fracture: status post recent ortho follow up. PT and OT is ongoing.On 12/10/25 at 10:04AM, Observed R11 sitting in wheelchair in her room. She is alert with impaired hearing and slurred speech. The call light is again away from her, unable to reach. Showed observation to V2 DON (Director of Nursing). V2 said that call light should be accessible and placed within resident reach for safety. Facility's policy on Call light uses and response revision date 7/18/23 indicated: Purpose: 1. To respond promptly to resident's call for assistance.Procedure: 9. Be sure call lights are placed within reach at all times. Facility's policy on Care Plan Baselined and comprehensive revision date 7/18/24 indicated: Policy: The interdisciplinary team will develop an individualized, comprehensive care plan for each resident based on their medical condition, medical history, assessment from different members of the interdisciplinary team, lifestyle, and current resident goals. Facility's policy on Post fall revision date 10/13/23 indicated: Purpose: To ensure safe and appropriate care is provided to the resident after a fall has occurred. To implement new intervention to reduce the risk of further incidents. Root Cause Analysis and care plan:*Identify the underlying causes and risk factors of the fall*Current fall interventions will be reviewed for continued effectiveness. Care plan will be updated with new interventions based on the root cause of fall. *New intervention is monitored for effectiveness.Facility's policy on Fall Reduction revision date 10/13/23 indicated: Purpose:*To identify residents who are risk for falling and develop appropriate interventions to provide supervision and assistance devices to prevent or minimize fall related injuries. *To promote a systematic approach and monitoring process for the care of residents who have fallen and or those who are determined to be at risk. Procedure: Risk identification and assessment: 2. Each resident will be evaluated for risk for falls using the Morse Fall scale upon admission, readmission, upon a significant change of condition, quarterly and following each fall3. Residents with a Morse Fall Scale score greater that 45 should be considered at high risk for falling and a score ranging from 25-44 are at moderate risk for falling. Prevention and Treatment guidelines:1. Any risk factors identified by the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Morse Fall Scale, MDS or other assessment should be reviewed and addressed as determined appropriate through the RAI (MDS) process including the resident's care plan.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, interview and record review the facility failed to ensure pain was thoroughly assessed and adequately treated for teeth pain for one of three residents (R6) in a sample of nine reviewed for pain.Findings include:On 12/10/2025 at 11:00am R6 was observed in bed with dark areas, a foul odor to mouth and broken teeth with yellow to brown build up. R6 was asked did she have pain to her teeth R6 said pain.On 12/10/2025 at 11:25am V2(Director of Nursing-DON) said I expect all nurses to assess for pain, I did assess R6 for mouth pain and R6 did confirm that she was in pain which I administered acetaminophen 625mg two tabs and called the physician for an assessment for dental ASAP and notified the power of attorney-POA.An admission record dated 12/10/2025 indicates that R6 has an diagnosis of Hemiplegia and Hemiparesis following nontraumatic subarachnoid hemorrhage affecting left dominant side, dysphagia, oropharyngeal phase, GERD, and gastrostomy status, an order summary report dated 12/10/2025 that indicates NPO diet for failed speech swallowing dated 7/17/2023, a care plan dated 4/17/2024 with a focus of ADL self-care performance deficit impaired mobility, impaired cognition, hemiplegia left side a interventions for personal hygiene/oral care assist-one with grooming, oral hygiene-oral care every shift and often if needed. An order summary report dated 12/10/2025 for pain management evaluate every shift using numerical or visual analog pain scale every shift for pain management, an order dated 5/18/2023 for acetaminophen 325mg two tabs via feeding tube every six hours as needed for pain do not exceed 3000mg for 24 hours. A care-plan dated 4/23/2024 potential for pain for generalized discomfort, intervention to administer medication per medical doctor order for pain management.Facility Policy: Revision date 6/25/2018, 11/26/2019, 4/27/2022 Pain Management and AssessmentPolicy:The purpose of this policy is to develop a standardized method for assessing, monitoring, evaluating, managing, and documenting pain in both cognitively intact and impaired residents. Residents will receive necessary comfort, exercise greater independence, and enhance dignity through optimizing their ability to perform activities of daily living.Procedure:3.Assess and document pain including onset and duration, location, severity, alleviating and aggravating factors, possible causes, and accompanying signs and symptoms.a. staff will assess for pain using a consistent approach and a standardized pain assessment instrument appropriate to the resident's cognitive level.

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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 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. Based on observation, interview and record review, the facility failed to ensure dental services were provided for a dependent resident for one of three residents (R6) reviewed for dental services in a sample of nine.Findings Include:On 12/9/2025 at 11:00am this writer observed R6 teeth very dark, broken in places, and a build up of yellowish film and foul odor.On 12/9/2025 at 11:20am this writer asks V2(Director of Nursing-DON) when was R6 last dental referral or exam.On 12/9/2025 at 11:25am V2 said I was unable to find a dental referral for R6, I did call the physician for a referral as soon as possible, I think because she is private pay, she has not had a dental exam she's been here for several years. An admission record dated 12/10/2025 indicates that R6 has an diagnosis of Hemiplegia and Hemiparesis following nontraumatic subarachnoid hemorrhage affecting left dominant side, dysphagia, oropharyngeal phase, GERD, and gastrostomy status, an order summary report dated 12/10/2025 that indicates NPO diet for failed speech swallowing dated 7/17/2023, a care plan dated 4/17/2024 with a focus of ADL self-care performance deficit impaired mobility, impaired cognition, hemiplegia left side a interventions for personal hygiene/oral care assist-one with grooming, oral hygiene-oral care every shift and often if needed. Facility Policy: Issue Date 1/6/2020 Oral Assessment and ManagementEvery resident will have a complete, accurate, and comprehensive assessment of oral status and needs consistent with residents' dental/oral status upon admission, with significant change or concerns noted, quarterly and annually.Procedure.1.Licensed nursing staff will complete an oral/dental review for every new resident.d. Inspect oral tissue and under dentures for presence of ulcers, masses oral lesions cavities, bleeding gums or loose teeth, soreness dried cracked lips, NPO pain or discomfort.2. Resident will be offered dental services upon admission and reviewed quarterly during care conferences.3. Dental/Oral concerns including but not limited to mouth pain, poor fitting dentures, pain/difficulty eating will ne addressed nursing and the provider updated with concerns.A. Facility will assist with making arrangements for dental services as ordered the provider.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145852	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Vista Prospect Heights	700 East Euclid Avenue Prospect Heights, IL 60070

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review the facility failed to perform hand hygiene after providing incontinence care and before handling clean disposable brief. This deficiency affects one (R11) of three residents in the sample 9 reviewed for Infection Control Program.Findings include: On 12/9/25 at 11:31AM, Observed V15 CNA (Certified Nurse Assistant) and V16 CNA repositioned R11 to her left side. Observed R11 soiled with urine. V15 removed the soiled disposable adult brief. She cleansed the perinium and sacral area with disposable cleansing wipes. V15 did not remove and perform hand hygiene. V15 took clean disposable adult brief and placed underneath R11. Informed V15, V16 and V3 ADON (Assistant Director for Nursing) of observation made regarding failure to perform hand hygiene after providing incontinence care and before handling clean adult brief. V3 said that V15 should perform hand hygiene after incontinence care and before handling clean brief. On 12/9/25 at 12:01PM, Informed V2 Director of Nursing (DON) of above observation and concern. Requested for hand hygiene policy. Facility's policy on hand Hygiene revision date 5/8/24 indicated: Purpose: To provide guidance to staff for proper and appropriate hand washing and hygiene techniques that will aid in the prevention of the transmission of infections. Washing Hands with Soap and Water1. Staff will perform hand hygiene by washing hands for at least 20 seconds with antimicrobial or non-antimicrobial soap and water should be performed under the following conditions: a. When hands are visible soiled with dirty or soiled with blood or other body substances:c. After contact with blood, body fluids, secretions, mucous membranes, or non-intact skin:Using Alcohol-Based Hand Gel1. If the hands are not visibly soiled, used an alcohol-based hand rub for all the following situations: e. After handling items potentially contaminated with blood, body fluids or secretions.