STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146094	A. Building B. Wing	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Vista Burr Ridge	6801 Highgrove Boulevard Burr Ridge, IL 60527

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interviews and record review, the facility failed to follow its fall prevention policy and provide adequate supervision for one cognitively impaired resident who was identified as being at high risk for falls. This affected one of three residents (R1) reviewed for fall prevention. This failure resulted in R1 having two unwitnessed, avoidable falls occurring on the same day, following the second fall R1 was transported to the hospital, where the resident was diagnosed with a spinal compression fracture.Findings include:On 6/30/26 at 1:21 PM, V4's RN (registered nurse) stated that R1 had an unwitnessed fall on the hallway floor on the morning of 5/25/26. V4 stated that R1 was confused, at baseline. V4 stated that at the time of R1's fall, V4 and CNAs (certified nurse aides) were in other residents' rooms providing care. V4 stated that R1was able to self-propel in wheelchair. R1 was assessed, no injuries noted. V4 stated that R1's vital signs were stable, and neurological checks were ordered due to it being an unwitnessed fall. V4 stated that neurological checks are documented in the residents' progress notes. When questioned regarding documentation that a bed/chair alarm in place and functioning, V4 responded R1 did not have a bed/chair alarm; she was referring to a floor mat next to bed and the call light kept within reach in room. V4 stated that R1 fell in hallway so no fall precautions were in place at time of fall. V4 stated that R1 had one floor mat next to bed in room. V4 stated that post fall she placed an additional floor mat on the other side of R1's bed.R1's medical record, dated 5/25/26, V4 RN noted V5 CNA notified V4 that R1 was on the hallway floor. Fall was unwitnessed. R1 noted to be confused at the time of incident. R1 stated he doesn't remember why he's here and he wanted to leave to go to his daughter. Assessment completed immediately. No apparent injuries were noted at this time. Vital signs obtained and monitored. R1 assisted off floor and returned to safe position. Fall precautions reinforced. Bed/ chair alarm in place and functioning. Call light place within reach. Frequent monitoring initiated, R1 reminded to use call light for transfers/ ambulation. Environment checked for safety. Family notified of incident. Physician notified. V2 DON (director of nursing) notified. Neurological checks continued. R1 closely monitored for any change in condition and follow facility fall protocol.On 6/30/26 at 2:22 PM, V8 RN stated that R1 was sent out via EMS (emergency medical services) 911 after second fall on 5/25/26. V8 stated that R1 was unable to state what happened; R1 just kept repeating my back. V8 stated that R1 is alert and oriented to person; baseline is confused. V8 stated that V8 did not perform any neurological checks or obtain vital signs prior to R1's fall; fall happened at beginning of her shift and EMS crew arrived soon after fall.On 6/30/26 at 2:30 PM, V7 CNA stated that R1 was in the common area, and she and the other CNA were in another resident's room providing care at the time of R1's fall. V7 stated that incident occurred just prior to dinner, about 4:45 PM - 5:00 PM.On 7/2/26 at 10:30 AM, when questioned if staff are expected to supervise residents, V2 DON (director of nursing) responded that V2 would prefer the staff to monitor the residents. V2 acknowledged that it is unclear if vital signs documented at 2:31 PM were obtained at 10:00 AM after first fall. V2 stated that R1 was sent out EMS 911 and does not believe vital signs were taken; R1 complained of back pain and was sent out immediately.R1's EMS report, dated 5/25/26, notes that the facility contacted EMS dispatcher at 3:53 PM. The crew were on scene at R1 at 4:03 PM. Staff stated that R1 attempted to stand up from (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	wheelchair and walk when R1 stumbled and fell to the floor. R1 complained of neck and lower back pain.R1's hospital records, dated 5/25/26, were unavailable for review during this survey.R1's medical record, dated 5/25/26, V8 RN noted R1 noted in dining room on the floor after an unwitnessed fall. Assessment completed immediately. R1 alert and responsive with altered mental status noted to be at baseline. No loss of consciousness observed or reported. Pupils are equal, round, and reactive to light and accommodation. No visible lacerations, hematoma, or active bleeding noted to head. R1 complained of back pain following incident. No obvious deformities noted. Skin warm and dry. Vital signs are unremarkable. R1 transported to the emergency room further evaluation. R1 is admitted to hospital with the diagnosis of altered mental status, pneumonia, and compression fracture of the spine.There is no documentation found noting R1's vital signs were obtained after second fall.R1's falls report, dated 5/25/26 at 10:00 AM, notes R1 alert and oriented to person, baseline. Predisposing factors: confused, gait imbalance, and impaired memory.R1's admission fall risk assessment, dated 5/23/26, notes R1 is at high risk for falls.R1's prior to admission hospital record, dated 5/21/26, PT (physical therapy) noted R1 needs moderate assistance with transfers. Barriers identified by PT: limited safety awareness, impulsivity, cognitive deficit, confusion, decreased endurance, impaired balance, and impaired coordination. R1's gait unsafe, unsteady, shuffling gait with variable cadence, poor safety awareness, needs assistance with rolling walker management and sequencing, forward flexed posture.The facility's fall prevention, post fall, and communication policy, dated 1/21/26, notes in part to promote resident safety by identifying fall risk to prevent recurrence. Post fall response: check the vital signs, look for subtle cognitive changes, and check the pupils and orientation. Document the resident's condition and clinical findings, such as vital signs.