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	12/31/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to assist residents identified as needing assistance with personal hygiene and grooming.This applies to 4 of 4 residents (R7, R9, R10 and R16) reviewed for ADL (activities of daily living) in the sample of 12.The findings include:1. R10 has multiple diagnoses including, unspecified dementia without behavioral disturbance, based on the face sheet. R10's admission MDS (minimum data set) dated November 13, 2025 showed that the resident was severely impaired with cognition and required total assistance from the staff with most of her ADLs including upper body dressing and personal hygiene. On December 28, 2025 at 11:18 AM, R10 was in her wheelchair inside the dining room. R10 was alert and was able to respond appropriately to simple questions. R10 had long curling facial hair above her lips mostly on the right side, her fingernails were uneven (some were long and some were short), some were jagged with chipped red nail polish and under her fingernails were dark substances. R10 was wearing a black shirt that had white stains and food debris on the front by the chest and abdominal areas. According to R10 she needs the staff assistance, and she wanted the staff to remove her facial hair, clean and trim her fingernails and change her shirt. On December 29, 2025 at 9:59 AM, R10 was sitting in her wheelchair inside the dining room. R10 had long curling facial hair above her lips mostly on the right side, her fingernails remained uneven (some were short, and some were long), some were jagged with chipped red nail polish and under her fingernails were dark substances. V3 (ADON, Assistant Director of Nursing) was present during the observation. R10's active care plan last revised by the facility on November 10, 2025 showed that the resident has an ADL self-care performance deficit. The care plan showed the facility's goal for R10 was to receive assistance with ADLs as evidenced by the resident's well-groomed appearance. The same care plan showed multiple interventions including provision of assistance with dressing and personal hygiene. 2. R9 has multiple diagnoses including, diabetic mellitus with diabetic chronic kidney disease, absolute glaucoma and unspecified rheumatoid arthritis, based on the face sheet. R9's admission MDS dated [DATE] showed that the resident was moderately impaired with cognition and required total assistance from the staff with most of her ADLs including personal hygiene. On December 28, 2025 at 10:56 AM, R9 was in bed, alert and oriented. R9 had accumulation of long facial hair above her lips and on her chin area. R9's fingernails were long; some were jagged with black substances under the nails. According to R9 she needs the assistance of the staff to remove (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: 146094	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/31/2025
NAME OF PROVIDER OR SUPPLIER Eden Vista Burr Ridge		STREET ADDRESS, CITY, STATE, ZIP CODE 6801 Highgrove Boulevard Burr Ridge, IL 60527	

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	her facial hair and provide nail care. R9 stated, I do not know how much they charge but I want my facial hair shaven, and my fingernails trimmed and cleaned. On December 29, 2025 at 11:27 AM, R9 was in bed, alert and verbally responsive. R9 had accumulation of long facial hair above her lips and on her chin area. R9's fingernails were long; some were jagged with black substances under the nails. V2 (DON, Director of Nursing) was present during the observation and had acknowledged that R9 needs staff assistance with nail care and shaving of facial hair. R9's active care plan last revised by the facility on December 22, 2025 showed that the resident has an ADL self-care performance deficit. The same care plan showed multiple interventions including provision of assistance with personal hygiene. 3. R16 had multiple diagnoses including, unspecified Alzheimer's disease and unspecified dementia without behavioral disturbance, based on the face sheet. R16's quarterly MDS dated [DATE] showed that the resident was severely impaired with cognition and required total assistance from the staff with most of her ADLs including upper body dressing and personal hygiene. On December 28, 2025 at 11:33 AM, R16 was sitting in her wheelchair inside the dining room. R16 was confused. R16 was wearing an orange shirt with printed design and a light blue zip up hoodie. R16's orange printed shirt had food debris and the resident's fingernails were uneven (some were short, and some were long) with most of the fingernails jagged and some with black substances under the nails. On December 29, 2025 at 10:05 AM, R16 was in bed, alert and verbally responsive. R16's fingernails remained uneven (some were short, and some were long), most of the fingernails were jagged and some had black substances under the nails. V3 (ADON) was present during the observation and stated, Yes, her fingernails need care. R16's active care plan last revised by the facility on October 20, 2025 showed that the resident has an ADL self-care performance deficit. The care plan showed the facility's goal for R16 to receive assistance with ADLs as evidenced by the resident's well-groomed appearance. The same care plan showed multiple interventions including providing assistance with dressing and personal hygiene/grooming due to R16's dependence. On December 29, 2025 at 11:31 AM, V2 (DON) stated that it is part of the facility's nursing care and services to provide assistance to all residents requiring help with nail care, dressing and removal of unwanted facial hair to ensure the residents maintain personal hygiene and grooming. 4. Face sheet shows R7 is 91 years-old who has multiple medical diagnoses including dementia, diabetes, and muscle wasting and atrophy. R7's Minimum Data Set (MDS) dated [DATE], shows R7 requires assistance with grooming and hygiene. From December 28 to 30, 2025, R7 was observed multiple times in the dining room and his bedroom. R7 displayed unkept overgrown facial hair and jagged, uneven, dirty fingernails with black/brown substance underneath. On December 29, 2025, at 12:18 PM, R7 stated he wanted his fingernails clipped and facial hair shaven.

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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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide mechanically altered food consistency for residents prescribed the level 6 soft and bite sized diet. This applies to 4 of 4 residents (R1, R16, R19, R30) reviewed for altered consistency diets in the sample of 12. The findings include:The Facility's diet type report dated December 29, 2025, showed R1, R16, R19, and R30 were prescribed the #6 soft and bite sized diet. R1's face sheet showed R1 was [AGE] years old, admitted to the facility on [DATE], and had multiple diagnoses including sepsis, protein calorie malnutrition, vascular dementia, presence of gastrostomy tube, Dysphagia, pharyngeal phase, and type 2 diabetes.R1's physician order showed Regular diet, Level 6 Soft & Bite Sized texture, Level 0 Thin (Regular) consistency initiated on December 16, 2025. R1's Speech Therapy recommendations dated December 5, 2025, showed to initiate po (oral) diet of mechanical soft/thin using small bites/sips and slow rate. R1's therapy recommendations also showed to advance R1's diet with the presence of speech therapy.On December 29, 2025, at 12:20 PM, R1's lunch meal as served included pork roast in larger cut pieces, whole California medley vegetables with large pieces of cauliflower, broccoli, and carrot slices with firm texture, mound of whole scalloped potatoes. The meal consistency served was the same as for the regular diets. R1 was not served the strawberry shortcake slurry for dessert.The lunch menu for the #6 soft and bite sized lunch meal showed roast pork, California vegetables and scalloped potatoes were to be served cut into small pieces and dessert was to be a slurry biscuit with strawberry glaze.On December 29, 2025, at 5:00 PM R1's dinner meal served included bratwurst sausage with the skin on cut on large slices, lettuce, tomato, and cucumber salad, with skin on the cucumber. The pieces of tomato chunks, pieces of lettuce were large and half slices of cucumber. R1 was attempting to cut the tomato with his knife and was not eating the sausage. R1 had no bread slurry served and had large slices of peaches and half strawberries and chunks of melon for fresh fruit.in liquid in the bowl.V4 (Culinary Director) came to R1's table and was asked about the size of the food served. V4 stated the pieces of the bratwurst were too big and the salad as served pieces were too large. V4 stated for the soft and bite sized diet, the food was supposed to be only as big as the tines of a fork. V4 was asked what a slurry bun was and replied it is the bread softened in milk and stated it was not prepared and served.The menu for the dinner meal for the #6 soft and bite sized, showed for the dinner meal the bratwurst sausage was to have the skin removed and was to be cut into small pieces, there was no salad on the menu to be served, there were no green beans prepared as described on the menu, no bread slurry prepared, and fruit was not prepared into soft and bite size pieces. R19's face sheet showed R19 was admitted to the facility on [DATE],was [AGE] years old and had multiple diagnoses including pneumonia, polyneuropathy, chronic diastolic congestive heart failure, gastro esophageal reflux disease, and taeniasis.R19's physician order showed diet order initiated on December 15, 2025, showed Regular diet, Level 6 Soft & Bite Sized texture, Level 0 Thin (Regular) consistency liquids.On December 29, 2025, at 12:20 PM, R19's tray ticket showed diet order was for 6 soft and bite size diet. R19 was served pork roast that was cut into large pieces, whole California medley vegetables including large pieces of cauliflower, broccoli, and carrots that were firm texture and mound of scalloped potatoes. There was no strawberry shortcake slurry served to R19.On December 29, 2025, at 5:00 PM, R19 was served bratwurst sausage with the skin still on and cut into slices, large pieces of lettuce and tomato salad, there was no bread slurry, no green beans nor fruit served to R19. R19 was pushing the food around on his plate. R16's face sheet showed R16 was admitted to the facility on [DATE], R16 was [AGE] years old, and had multiple diagnoses including Alzheimer's disease, chronic diastolic congestive heart failure, type 2 diabetes, and unspecified protein calorie malnutrition.R16's physician orders showed diet order initiated on October 21, 2025, was Regular diet, Level 6 Soft & Bite Sized texture, Level 0 Thin (Regular) consistency liquids. R30's (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	face sheet showed R30 was admitted to the facility on [DATE], was [AGE] years old, and had multiple diagnoses including chronic obstructive pulmonary disease, protein calorie malnutrition, type 2 diabetes, gastroesophageal reflux disease, and metabolic encephalopathy.R30's diet order initiated on December 24, 2025, showed regular diet, Level 6 Soft & Bite Sized texture, Level 0 Thin (Regular) consistency liquids.On December 28, 2025, at 10:50 AM during the initial kitchen observation, V4 identified there was 1 resident prescribed a puree diet and 4 residents prescribed mechanically altered diets. There was no mechanically altered consistency food prepared for the lunch meal.The December 28, 2025, lunch meal menu for the #6 soft and bite sized menu showed the entree was roast beef and roasted vegetables to be served in small and bite sized pieces without skin, a slurry bread roll with margarine and no crust cherry pie.The facility's policy, undated, for texture modification diets in accordance with IDDSI (International Dysphagia Diet Standardization Initiative) showed #6 soft and bite sized diet are foods that can be mashed/broken down with pressure from a fork, into bite sized pieces, soups and fruits are drained, bread is soaked. No regular dry bread, sandwiches, or toast of any kind. Additional instructions for IDDSI level 6 soft and bite sized diet showed foods are cut into pieces no larger than 1.5 cm (centimeter) x 1.5 cm, and no mixed consistencies such as liquids mixed with solids (i.e. like chunky vegetable soup, or fruit cups in juice).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow standard infection control practices related to hand hygiene and gloving during provisions of incontinence care and administration of medication. The facility also failed to ensure that staff would wear complete PPE (personal protective equipment) during provision of care for residents who are on EBP (Enhance Barrier Precaution). This applies to 5 of 12 residents (R2, R3, R7, R10, R18) reviewed for infection control in the sample of 12. The findings include: 1. On December 29, 2025, at 10:23 AM, V5 (Nurse) administered multiple medications to R10. When R10 showed sign that she was having difficulty swallowing her medications, V5 took the CO Q10 capsule and Acidophilus capsule of R10, without hand hygiene she opened it with her bare hands mixed it to an apple sauce and gave it to R10. Prior to directly touching R10's medication, V5 was touching different objects and other surfaces. On December 30, 2025, at 2:57 PM, V12 (Nurse) stated when opening a capsule medication, they are supposed to sanitize their hands first and don't touch anything prior to touching a medication to prevent contamination of medication. 2. During initial rounds on December 28, 2025, at 10:30 AM, there was an EBP (Enhance Barrier Precaution) signage on R18's door. V2 (Director of Nursing/DON) stated that R18 has a wound on his leg that requires wound care which was the reason for EBP. On December 29, 2025, at 11:56 AM, V6 and V7 (Both Certified Nursing Assistant/CNA) rendered incontinence care to R18 who had a bowel movement and was wet with urine. V6 and V7 wore gloves but did not wear complete PPE. During the provision of incontinence care, V6 donned double layers of gloves and proceeded to clean R18 from front to back of the perineum. Then V6 removed the first layer of gloves and applied barrier cream, with the same gloves V6 applied new incontinence brief. V6 removed her second layer of gloves and without hand hygiene continued to assist R18 to dress. 3. On December 29, 2025, at 12:08 PM, V6 (CNA) assisted R7 to the toilet to urinate. V6 assisted R7 to sit on the toilet riser and ensure that R7's urine will flow inside the toilet bowl. Afterwards, V6 cleaned R7's perineum, removed soiled brief and placed a new clean brief, pulled brief and pants up and assisted R7 back to the wheelchair while wearing same soiled gloves, and without hand hygiene from dirty to clean tasks. 4. On December 30, 2025, at 9:44 AM, V6 and V7 rendered incontinence care to R3. V6 cleaned R3 from front to back of his perineum, she applied new incontinence brief, repositioned R3, and straightened his bed linen, while wearing the same soiled gloves. She removed the PPE right after completion of care and left the room without hand hygiene. On December 30, 2025, at 10:43 AM, V2 (Director of Nursing/DON) stated staff must wear complete PPE when providing direct care to residents on EBP to prevent potential spread of infection or cross contamination. 5. On December 29, 2025 at 3:56 PM, V9 (CNA) with the assistance of V10 (CNA) provided incontinence care to R2. R2's disposable brief was wet with urine and the resident also had pasty stool. While donning a pair of gloves, V9 cleaned R2's anal and perineal areas, then using the same soiled gloves, V9 applied a clean disposable brief to the resident, pulled-up R2's pants and then touched the bed control to lower R2's bed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On December 29, 2025 at 4:20 PM, V9 acknowledged that she did not remove her used/soiled gloves and did not perform hand hygiene after providing incontinence care to R2, before applying clean disposable brief, pulling R2's pants and touching the resident's bed control. On December 30, 2025 at 10:43 AM, V2 (Director of Nursing) stated that after providing incontinence care to a resident, the staff should remove their gloves and perform hand hygiene either by washing their hands or using alcohol rub/sanitizer before proceeding to perform clean task including application of clean disposable brief, touching resident's garment and touching resident's equipment such as bed control to prevent cross contamination and to maintain infection control. The facility's hand hygiene policy and procedure last revised by the facility on May 8, 2024 showed, To provide guidelines to staff for proper and appropriate hand washing and hygiene techniques that will aid in the prevention of the transmission of infections. Under procedures it showed, 2. The use of gloves does not replace hand hygiene. 3. Hand hygiene is always the final step after removing and disposing of personal protective equipment (PPE). The policy under, washing hands with soap and water showed, 1. Staff will perform hand hygiene by washing hands for at least twenty (20) seconds with antimicrobial or non-antimicrobial soap and water should be performed under the following conditions: . b. Before applying gloves and after removing gloves or other PPE.d. After handling items potentially contaminated with blood, body fluids, or secretions. e. Before moving from a contaminated body site to a clean body site during resident care; example: after providing peri-care, before applying moisture barrier or other treatments. The same policy under, using alcohol-based hand gel showed, 1. If hands are not visibly soiled, use an alcohol-based hand rub for all the following situations: . d. Before applying gloves and after removing gloves or other PPE; e. After handling items potentially contaminated with blood, body fluids, or secretions; f. Before moving from a contaminated body sites to a clean body site during resident care; example: after providing peri-care, before applying moisture barrier or other treatments; .l. Before moving from a contaminated body site to a clean site during resident care; m. After contact with inanimate objects (for example medical equipment) in the immediate vicinity of the resident. The facility's policy and procedure regarding EBP (Enhanced [NAME] Precautions) dated March 26, 2024 showed, It is the policy of this facility that Enhanced Barrier Precautions, in addition to Standard and Contact Precautions will be implemented during high-contact resident care activities when caring for residents that have an increased risk of acquiring a multidrug- resistant organism (MDRO) such as a resident with chronic wounds requiring a dressing, indwelling medical devices or residents with infection or colonization with an MDRO. The purpose of Enhanced Barrier Precautions is to prevent opportunities for transfer of MDROs to employee's hands and clothing during cares, beyond situations in which staff anticipate exposure to blood or body fluids. The same policy under procedure showed, 5. For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities including changing linens and changing briefs or assisting with toileting. The facility's policy and procedure regarding PPE (Personal Protective Equipment) last revised by the facility on June 14, 2024 showed that glove use does not replace hand hygiene and to immediately complete hand hygiene after removing gloves. The same policy showed that after applying non-sterile gloves, the said gloves should be removed after a procedure, discard the used gloves in appropriate containers and perform hand hygiene.

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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. Based on observation, interview, and record review, the facility failed to apply a recommended device for contracture management to resident who has contractures. This applies to 2 of 3 residents (R3, R11) reviewed for contractures in the sample of 12. The findings include: 1. Face sheet shows R3 is 78 years-old who has multiple medical diagnoses including hemiplegia and hemiparesis affecting left non-dominant side. R3 is under hospice care. The therapy services/screening form dated September 16, 2025, shows R3 was provided a resting hand splint but it was missing, the facility notified hospice nurse. R3's care plan with a target date of January 1, 2026, shows, R3 has an ADL (Activities of Daily Living) self-care performance deficit related to hemiplegia, and left-hand contracture. This same care plan shows multiple interventions including application of left-hand splint, on for 12 hours and off for 12 hours. On December 28, 2025, at 10:48 AM, R3 was observed multiple times resting in bed, he was alert with periods of confusions. R3 displayed contracted to left arm and hand. R3's left hand was tightly clenched with his fingers digging onto his palm. There was no palm protector or resting hand splint on his hand. From December 28 to December 30, 2025, multiple observations were conducted to R3 who was resting in bed. R3's left hand remained clenched with no resting splint nor rolled towel on his hand. On December 30, 2025, at 9:44 AM, V6 (Certified Nursing Assistant/CNA) provided incontinence care to R3 who was totally dependent on staff for his ADL care. R3 was pleasant and cooperative. R3's left hand was tightly clenched, and remained with no resting splint, there was a thin dressing on his left palm which V6 stated to protect his skin from his fingernails. V6 stated that R3 used to have a carrot splint. There was no resting hand splint/carrot splint, nor rolled washcloth present anywhere on R3's bedroom during observations from December 28 to 30, 2025. 2. Face sheet shows R11 is 73 years-old who has multiple medical diagnoses including dementia, functional quadriplegia, and contracture, unspecified joint. The therapy services/screening form dated September 16, 2025, shows R11 has contractures of upper and lower extremities. R11 needs cuing to relax limbs and needs pillow placement to increase comfort and decrease skin breakdown. On December 28, 2025, at 10:45 AM, R11 was resting in bed, her hands, wrists, and bilateral lower extremities were contracted. R11's lower extremities were contracted and adducted with skin touching and rubbing on one another, there was no wedge pillow in between the knees. R11 was totally dependent on staff for ADL care. From December 28 through December 30, 2025, R11 was observed multiple times in bed. There was no pillow in between her lower extremities which was pressed and rubbing together R11's care plan with target date of January 1, 2026, shows R11 has contracture, quadriplegia and chronic pain syndrome. This same care shows multiple interventions including use of non-pharmacological pain mechanisms such as positioning comfortably.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to follow physician order and manufacturer's recommendation for medication administration. There were 26 medication opportunities with 2 administration errors resulting to 7.69% medication error rate. This applies to 1 of 2 residents (R10) reviewed for medication administration in the sample of 12. The findings include:Face sheet shows that R10 is 92 years-old who has multiple medical diagnoses including dementia, dysphagia, hypertension, tachycardia, and hypothyroidism. On December 29, 2025, at 10:23 AM, V5 (Nurse) administered multiple medications to R10 including Levothyroxine and Aspirin chewable tablet. Both medications were crushed upon administration, which made the Aspirin medication an immediate release dose. V5 said that R10 already ate breakfast prior to administration of morning medications. On December 30, 2025, at 12:57 PM, V1 (Administrator) stated they expect the nurses to relay pharmacy recommendation to the physician and follow physician's instructions/orders. Synthroid is given early in the morning on an empty stomach to get its full effect or to ensure optimal absorption of the medication On December 30, 2025, at 3:00 PM, V12 (Nurse) stated Synthroid is given at 6 AM before breakfast on an empty stomach to increase effectiveness of medication. It is less effective after resident has eaten. R10's Physician Order Summary (POS) shows: Levothyroxine Sodium Oral Tablet 50 mcg. Give 1 tablet by mouth one time a day for hypothyroidism. This medication is time sensitive, should be given at 6 AM, earliest time to give is at 5AM. Aspirin 81 Oral Tablet Delayed Release. Give 1 tablet once a day for VTE (Venous Thromboembolism). Manufacturer's recommendation for the Levothyroxine showed to administer this medication on an empty stomach, one half hour to one hour prior to breakfast with a full glass of water.