STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016216	A. BUILDING: _____ B. WING _____	C 05/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDEN VISTA BURR RIDGE	6801 HIGHGROVE BOULEVARD BURR RIDGE, IL 60527

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S 000	Initial Comments Facility Report Investigation to incident of 4/21/2025, IL190982	S 000		
S9999	Final Observations Statement of Licensure Violations 330.710 a), 330.710 c) 2) 330.710)c)3) H) a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated with the involvement of the administrator. The written policies shall be followed in operating the facility and shall be reviewed at least annually by the Administrator. The policies shall comply with the Act and this Part. c) The written policies shall include, but are not limited to, the following provisions: 2) Resident care services including physician services, emergency services, personal care services, activity services, dietary services and social services. 3) A policy to identify, assess, and develop strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident. The policy shall establish a process that, at a minimum, includes all of the following: H) Fostering and maintaining resident safety,	S9999		

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S9999	Continued From page 1	S9999		

dignity, self-determination, and choice. (Section 3-206.05 of the Act)

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that a resident was safe during provision of incontinence care.

This applies to 1 of 3 residents (R1) reviewed for fall in the sample of 3.

This failure resulted in R1 falling while being assisted by two staff. R1 was hospitalized and was diagnosed with left femur fracture requiring ORIF (Open Reduction Internal Fixation) surgical procedure.

The findings include:

R1 was admitted to the facility on November 12, 2024 with multiple diagnoses including lack of coordination, need for assistance with personal care, periprosthetic fracture around internal prosthetic of the right knee joint, obesity, unsteadiness on feet and history of falling, based on the face sheet.

R1's service plan dated November 12, 2024 showed that the resident was oriented and required two person hands on assistance for transfer and mobility. The same service plan showed that R1 required two person hands on assistance with toileting, including the application of incontinence products and related hygiene needs.

R1's fall risk assessment dated March 31, 2025 showed a score of "4." On May 2, 2025 at 3:15

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PM, V3 (Assistant Director of Nursing/Sheltered Care coordinator) stated that a fall risk assessment with a score below 12 meant that the resident is at risk for fall.

R1's fall incident report dated April 21, 2025 at 8:10 AM created by V6 (LPN/Licensed Practical Nurse), showed that the resident had a fall during staff assisted care. The report showed in-part, "The CNA (Certified Nursing Assistant) on duty alerted writer/nurse that during an attempted transfer, the resident's knees buckled, and she allowed her to slide to the floor." The report showed that R1 was instructed to remain still due to a complaint of pain to the left hip and leg, and 911 was called. The same report documented the statement of V4 (CNA) which showed, "On Monday, [April 21, 2025], I went to the resident's room to get her up and ready for breakfast. I had another aide in there with me and we lifted her off the chair as she held onto her walker. After she gained her balance, I started changing her brief. Without warning all of a sudden, her knees buckled, and all her weight fell onto her left leg. I couldn't attempt to catch her because that could have resulted in both of us being injured. From there, I placed a pillow under her [head] and called for the nurse."

R1's progress notes dated April 21, 2025 at 8:10 AM, created by V6 (LPN) showed in-part, "Writer/Nurse was alerted per the residents assigned caregiver that during a transfer, the residents "knees buckled" and she slid her down to the floor where she was observed lying supine near recliner chair with wheelchair nearby. She was noted to be alert and oriented, aware of situation. The resident was instructed to remain still due to a complaint of pain to the left hip and leg. 911 was called." Further review of R1's

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progress notes dated April 21, 2025 showed that the resident's physician and POA (Power of Attorney) were notified of the fall incident and the transfer to the hospital emergency department. R1's progress notes dated April 21, 2025 at 10:26 AM, showed that the resident was admitted to the hospital with diagnosis of left femur fracture.

R1's hospital records documented an x-ray result of the left hip dated April 21, 2025 which showed that the resident sustained displaced comminuted spiral fracture of the distal left femoral diaphysis. The hospital records showed that ORIF (open reduction internal fixation) surgical procedure was performed.

On May 2, 2025 at 12:45 PM, V4 (CNA) stated that she was the assigned staff to R1 on March 21, 2025 during the morning shift. V4 stated that on March 21, 2025 at around 8:00 AM she was assisted by V5 (CNA) to get R1 ready for breakfast. V4 stated that R1 sleeps in her reclining chair. According to V4 while R1 was still sitting in her reclining chair, she (V4) positioned herself on R1's right side, grabbed the back of the resident's pants to assist R1 to stand, while V5 was standing in front of the resident holding R1's walker. V4 stated that while R1 was standing holding on to her walker, she (V4) pulled down R1's pants by the ankle, removed R1's soiled disposable brief and started to provide incontinence care to the resident, while V5 remained in front of R1, holding the resident's walker. V4 stated that after cleaning R1, she (V4) started to place a new disposable brief to the resident but because R1's thigh was thick due to her being overweight, R1 had to spread her legs more to be able to apply the brief properly and as soon she was able to get the brief in place between R1's legs (but not fastened), the

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resident's knees buckled and R1 fell towards her (R1) left side. According to V4, R1 fell on her left hip, then R1 instinctively sat on her buttocks, then lay flat on the floor. V4 stated that the incident happened very fast, and she was not able to prevent R1 from falling because there was nothing for her to grab on to, and V5 was also not able to prevent the resident from falling because she (V5) was in front of R1 holding the resident's walker. V4 stated that when R1 was on the floor, she placed a pillow under the resident's head, and she called V6 (LPN) to check on the resident. V4 added that V6 came immediately and because R1 complained of left hip pain, V6 instructed not to move R1 and 911 was called to get R1 from the floor and bring the resident to the hospital. During the same interview, V4 stated that she would normally grab the back of R1's pants to assist the resident to stand and a gait belt was never used.

On May 2, 2025 at 1:05 PM, V5 (CNA) stated that she assisted V4 (CNA) on March 21, 2025 at around 8:00 AM to get R1 ready for breakfast. V5 stated that R1 sleeps in her reclining chair most of the time. While R1 was sitting in her recliner, she (V5) positioned herself in front of the resident to hold the walker for stability, while V4 positioned herself on the right side of R1. According to V5, while V4 was on the right side of R1, she (V4) grabbed the back of the resident's pants and assisted R1 to stand and hold on to the walker. While R1 was standing and holding on to the walker, V4 provided incontinence care and attempted to apply the disposable brief after the resident was cleaned. V5 stated that before V4 could fasten R1's brief, the resident said that her knees are buckling and then R1 fell. V5 does not remember which part of R1's body hit the floor first. V5 stated that during the incontinence care

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and when R1 was falling she remained positioned in front of the resident, holding on to the walker which was also being held by R1. According to V5, she was not able to prevent R1 from falling. V5 stated that V4 called V6 (LPN) to check on R1. R1 complained of pain on her left leg and the resident was sent to the hospital. During the same interview, V5 acknowledged that a gait belt was not used on R1 during the assistance to stand and during the incontinence care that was provided while the resident was standing.

On May 2, 2025 at 1:22 PM, V6 (LPN) stated that on March 21, 2025 between 8:00 AM and 8:10 AM, she was called by V4 (CNA) because R1 had a fall incident in the room. V6 stated that when she arrived at R1's room, the resident was on the floor with a pillow under her head and a walker near the resident. V6 does not remember how R1 was positioned while on the floor, however she remembers the resident complaining of pain on her left leg, so she instructed V4 not to move R1 and she (V6) immediately called 911 to get R1 from the floor and transport the resident to the hospital for further evaluation. V6 does not know how R1's ADL (activities of daily living) care are provided, because according to V6, she does not provide direct care to the residents.

On May 2, 2025 at 3:31 PM, V7 (Director of Rehab/PTA (Physical Therapist Assistant)) stated that R1 received both PT/OT (Physical Therapy/Occupational Therapy) from November 20, 2024 through January 15, 2025. V7 stated that when R1 was discharged from both PT/OT on January 15, 2025, the resident was able to transfer with moderate assistance, with one person physical assist and was able to ambulate 20 feet using a rolling walker with minimum assistance from the staff. According to V7, the

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therapy department always recommend the use of a gait belt during transfers for ease and safety and the gait belt is also always recommended to be used during toileting for safety, unless the resident is totally independent or is using a mechanical lift. V7 stated that the above recommendation to use a gait belt also applies to the sheltered care residents of the facility.

On May 2, 2025 at 3:46 PM, V3 (Assistant Director of Nursing and Sheltered Care coordinator) stated that based on R1's service plan, the resident is incontinent of both bowel and bladder functions and requires two staff assistance with transfers and toileting. V3 stated that she expects the staff to always use a gait belt during staff assisted transfers and during the provision of incontinence/perineal care while the resident is standing up to support the resident, to promote safety and to prevent fall or accident. According to V3, prior to R1's fall incident on March 21, 2025, she expected the staff to do either two things to provide safe incontinence care to R1. First, the two staff should assist R1 to walk to the bed, using the walker and a gait belt, transfer R1 to the bed and while in bed, incontinence care could be safely provided by the two staff. Second, the two staff should assist R1 to walk to the bathroom, using the walker and a gait belt, and perform incontinence care inside the bathroom where the resident could hold on to the grab bar and the two staff can safely assist with the care. According to V3, the staff should have used the walker and gait belt for support and stability because R1 was diagnosed with unsteadiness.

On May 3, 2025 at 10:18 AM, V8 (Physician) stated that he was informed of R1's fall on March 21, 2025 that required the resident to be

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S9999	Continued From page 7 hospitalized with diagnosis of left femur fracture. V8 stated that R1 was obese and for him it was not acceptable to provide incontinence care while the resident was standing up. According to V8, "the outmost precaution should have been done to ensure her (R1) safety during the care." The facility's policy regarding safe resident handling and mobility program last reviewed by the facility on February 15, 2023 showed in-part under the objectives, "Ensure that residents are cared for safely while maintaining a safe work environment for our employees, Facilitate the safe use of transfer aids and equipment, ... Provide a consistent technique for the assisting, repositioning or transfer of resident, ..." The facility's toileting/Incontinence care policy dated June 30, 2023 showed, "To provide residents a safe, hygienic, and thorough toileting assistance." The same policy under procedure showed, "1. Assist resident to the bathroom and gather any incontinence products as needed." (A)	S9999		