

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058602		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/05/2026	
NAME OF PROVIDER OR SUPPLIER EDEN VISTA BURR RIDGE				STREET ADDRESS, CITY, STATE, ZIP CODE 6801 HIGHGROVE BOULEVARD , BURR RIDGE, Illinois, 60527			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S0000	Initial Comments Facility Reported Incident of 1/19/2026 /2729145 Facility Reported Incident of 1/30/2026 /2745973		S0000				
S9999	Final Observations Statement of Licensure Violations: 330.710a) 330.710c)3)F)H)d)1) Section 330.710 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 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: 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: F) Development of 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. H) Fostering and maintaining resident safety, dignity, self-determination, and choice. (Section 3-206.05 of the Act) d) For the purposes of subsection (c)(3): 1) "Health care worker" means an individual providing		S9999				

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 direct resident care services who may be required to lift, transfer, reposition, or move a resident. (Section 3-206.05 of the Act) These REQUIREMENTS were not met as evidenced by: Based on interview and record review the facility failed to follow their policy and procedure regarding staff assistance during mechanical lift transfer. The facility also failed to have a policy and procedure in place that addresses strategies and steps to transfer a resident from the chair to the bed safely using a mechanical lift. This failure resulted in R2 hitting her right knee with the full body mechanical lift, resulting in acute comminuted fracture of the distal right femoral shaft that required surgery. This failure also resulted in R1 hitting her head on the headboard during mechanical lift transfer, resulting in lacerations that required application of staples. This applies to 2 of 3 residents (R1 and R2) reviewed for incidents with injury in the sample of 3. The findings include: 1. R2 had multiple diagnoses including diabetes mellitus, mild vascular dementia and age-related osteoporosis, based on the diagnosis sheet. R2's service plan assessment dated November 24, 2025, showed that the resident has "memory loss/dementia." The service plan assessment documented that R2 "requires assist of mechanical lift (total lift) with two staff assist" with transfer. The same service plan assessment showed R2's level of care was "5" which meant the resident required two-person maximum assistance with all ADLs (activities of daily living). R2's progress notes dated January 30, 2026, at 1:29 PM, created by V11 (LPN/Licensed Practical Nurse) showed, "CNA (Certified Nursing Assistant) came to NOD (Nurse on duty) office to report that during transfer, resident hit her knee against the [full body mechanical] lift. Upon entering room, resident was lying in bed waiting to be seen. Resident stated she isn't in any pain. NOD assessed knee for any redness, bruise, pain. NOD called [Physician] and [Physician] stated to do stat x-ray. POA (Power of Attorney) was notified and agreed to do the x-ray just in case. Resident stayed in bed for lunch just to relax." R2's late entry progress notes dated January 30, 2026,		S9999				

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S9999	Continued from page 2 at 4:22 PM showed, "Writer observed resident right knee swollen, an order was in place for X-ray. While waiting for the X-ray, writer contacted the resident's husband and updated him on the resident's condition, including right knee swelling, complaints of pain, and recommendation to send the resident to the ER (emergency room). The husband declined at that time and requested to wait for the X-ray to be completed. While waiting for the X-Ray, resident was administered PRN (as needed) Tylenol for pain management." R2's progress notes dated January 30, 2026, at 10:04 PM showed in-part, "Writer observed resident's right knee to be swollen, and resident complained of pain after hitting her knee against the [full body mechanical] lift during transfer. An X-ray was ordered; however, the X-ray could not be completed due to bad weather. Resident stated she was in severe pain and requested to be sent to the ER. PRN Tylenol was administered. [Physician] was notified, and an order was received to send the resident to the ER. [Private] ambulance was called and they arrived at 9:45 pm and transported the resident to [hospital]." R2's progress notes dated January 31, 2026, at 1:12 AM, showed that the resident was admitted to the hospital with diagnosis of femur fracture. R2's initial incident report submitted to the State Regulatory agency on January 31, 2026, showed that on January 30, 2026, at 10:10 AM, the resident had an incident categorized as injury of known origin. The report showed, "On [January 30, 2026] at approximately 11:17 AM, resident was noted to have pain to the right knee. [Physician] contacted and gave order for x-ray of right knee. Ice pack and pain medication were administered for pain management. Resident and POA were offered hospital transfer, which was declined by the husband. Husband wanted to wait for x-ray company. Husband eventually agreed to have resident sent to hospital. The resident was subsequently transferred to the hospital for further evaluation." The same report documented that R2 was diagnosed at the hospital with right femur fracture. R2's final incident report submitted to the State Regulatory agency on February 6, 2026, showed that the facility investigated the incident that occurred on January 30, 2026. The report showed that a therapist was interviewed and stated that on January 30, 2026, she went to the resident's room to pick her up for therapy session. She asked resident why she was still in bed, resident reported she fell while being transferred. The report showed that V12 (facility		S9999				

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S9999	Continued from page 3 caregiver) gave a statement that R2 did not have a fall on January 30, 2026, during her shift. V12 stated that R2 bumped her knee with the full body mechanical lift while she (V12) was applying the sling to the lift hook. V12 was re-interviewed by V1 (Administrator) and V12 maintained that R2 did not have a fall and that the knee pain was related to R2 bumping her knee while the lift pad (sling) was being hooked to the full body mechanical lift. The report showed that V8 (facility caregiver) gave a statement that she was asked by V12 to assist with the full body mechanical lift transfer. They completed the first [full body mechanical] lift transfer with no incident, resident did not complain of pain. Resident was in the dining room for lunch and asked for a pain pill and wanted to be transferred back to bed. Caregiver notified the nurse regarding complaint of pain and [V12 and V8] transferred resident back to bed with [full body mechanical lift] and no incident during either [full body mechanical] lift transfer she participated. The report documented that the facility had interviewed other staff who worked 48 hours previously (from January 30, 2026) and "found no prior injuries." The same final report showed, "In conclusion, after a complete and thorough investigation it was determined that resident could have had a fall incident prior to the 2 [full body mechanical] lift transfers without incident on day shift [January 30, 2026]. However, staff [V12] maintains no fall occurred. Resident with a diagnosis of Vascular Dementia, she is alert and oriented x 2 states she had a fall during transfer. Staff member [V12] maintains she hooked resident up to [the full body mechanical] lift while in bed, prior to obtaining second staff assistance and this is when resident bumped her knee." R2 returned to the community on February 5, 2026, post-surgical procedure on the skilled nursing facility unit to receive skilled therapy. R2's hospital records dated February 3, 2026, showed in-part under assessment and plan, "1. Fall with acute comminuted fracture of the distal right femoral shaft. Patient underwent right femur intramedullary nail and open reduction." On March 2, 2026, at 1:38 PM, R2 was sitting in her wheelchair inside the skilled unit dining room. R2 was verbally responsive. R2 was asked about the incident that led to her having a fracture on the right leg. R2 did not remember the incident. R2 commented that she hit her leg against the bed and that her husband was in the kitchen when the said incident happened. On March 2, 2026, at 1:56 PM, V7 (CNA) stated that on January 30, 2026, she was not the assigned staff for		S9999				

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S9999	Continued from page 4 R2. On the said date at around 9:00 AM, while R2 was inside the sheltered care unit dining room, the resident told her that she was having knee pain (does not remember which knee) and wanted to go back to bed. V7 stated that she immediately informed the assigned staff (V12/facility caregiver) about the knee pain and R2's request to go back to bed. According to V7, she saw V12 wheel R2 to the room and she believed that V8 (facility caregiver) assisted with transferring R1 to bed. However, she did not observe the transfer. V7 added that during her conversation with R2, the resident did not report that she had a fall during transfer that caused her knee pain. V7 stated that she did not witness and/or hear any report that R2 had a fall while being transferred prior to the resident complaining of knee pain. On March 2, 2026, at 2:24 PM, V3 (ADON/Assistant Director of Nursing) stated that V12 (facility caregiver) was terminated from the facility after the investigation of R2's incident that occurred on January 30, 2026. V3 stated that she was informed by V8 (facility caregiver) that on January 30, 2026, after breakfast she (V8) was called by V12 to assist in transferring R2 from the bed to the wheelchair. According to V8, when she arrived at R2's room, the resident already had the full body mechanical lift pad (sling) under her and the said lift pad was already attached/hooked to the mechanical lift. Per V8, she assisted with the transfer, and no incident occurred. V3 stated that upon interview with V12, she stated that while R2 was in bed, she applied the full body mechanical lift pad under the resident and attached the lift pad to the mechanical lift without the assistance of any other staff. According to V3, V12 admitted that while she was attempting to attach the lift pad to the mechanical lift bar, R2's right knee hit the mechanical lift but V12 did not give specifics as to which part of the mechanical lift hit the resident's right knee. V3 stated that V12's action of applying the lift pad and attaching it to the mechanical lift without the second staff present and assisting was a violation of the facility's policy. V3 stated that for all transfers using a mechanical lift, it is the facility's policy that two staff should be present to assist from start of the transfer including during the application of the lift pad and attaching the lift pad to the mechanical lift to completing the transfer to the wheelchair or to the bed to ensure resident's safety. During the interview, V3 stated that she provided an in-service on December 19, 2025, attended by V12 with regards to use of the mechanical lift. V3 provided the signed in-service as evidence. V3 stated that during the said in-service she told the staff not to touch the resident			S9999			

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S9999	Continued from page 5 to apply the lift pad and/or to attach the lift pad to the mechanical lift without the second staff. During the same interview, V3 stated that as part of the facility's investigation regarding R2's incident, she interviewed other staff who attended the resident three days prior to the incident on January 30, 2026, and on the day of the incident, including V12 and they all denied R2 having any fall incident during their respective shifts. V3 added that V12 also did not report to the nurse that R2 hit her right knee on January 30, 2026, and the nurse only found out about it after R2 complained of pain. On March 3, 2026, at 12:20 PM, V8 (facility caregiver) stated that on January 30, 2026, between 8:30 AM and 9:00 AM, she was asked by V12 (facility caregiver) to assist with R2's transfer. V8 stated that when she arrived at the resident's room, R2 was in bed with the full body mechanical lift pad under her and the said lift pad was already attached to the mechanical lift. According to V8 because R2 was already attached to the mechanical lift, the only assistance she provided was during the actual lift transfer. V8 added that during the transfer process, R2 did not complain or showed signs of pain or discomfort, and no fall incident had occurred during the transfer. During the same interview, V8 stated that she had received an in-service on December 20, 2025, regarding the use of the mechanical lift during transfer. According to V8, they were told during the in-service that two staff should be present to assist a resident during mechanical lift transfer, from start to the end, including from application of the lift pad, to attaching the lift pad to the mechanical lift, until the complete transfer to the bed or to the chair to prevent accident and ensure resident's safety. On March 3, 2026, at 12:31 PM, V9 (OT/Occupational Therapist) stated that on January 30, 2026, prior to R2 being sent to the hospital she went to the resident's room at the sheltered care side of the facility, to provide therapy. During that time R2 was in bed and stated that she had a fall incident while being transferred by the staff without the use of the mechanical lift. Per V9, R2 did not provide further information such as when the fall happened and who was the staff transferring her. According to V9 she reported R2's allegation of fall to her direct supervisor (V13/Rehab Manager). V9 stated that she provided upper body therapy to R2 while the resident was in bed and the resident did not complain or showed any signs of pain or discomfort at the time. According to V9 on January 30, 2026, she believes that R2 was cognitively intact and was aware that staff should		S9999				

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S9999	Continued from page 6 transfer her from bed to chair and vice-versa with the use of the mechanical lift. However, currently since being readmitted to the facility at the skilled unit post right femur surgery, she noticed that R2's cognitive status had declined. During the same interview, V9 stated that there should be two staff present when attaching the lift pad to the mechanical lift at all times to ensure that the lift bar does not hit the resident's head, arm, knee or any other part of the body and to ensure that the resident is centered in the lift pad when attached to the mechanical lift. On March 3, 2026, at 1:14 PM, V10 (Physical Therapist) stated she had evaluated R2 on February 13, 2026, when the resident got admitted to the skilled unit of the facility post hospitalization. V10 stated that based on the record, R2 was diagnosed at the hospital with acute comminuted fracture of the distal right femoral shaft and had surgery of the right femur. According to V10, because R2 had a diagnosis of age-related osteoporosis, it was possible that the resident could fracture her right femur by just by hitting her knee on an object such as the mechanical lift and it is also possible that R2 had a fall that caused the fracture, but she cannot be certain what exactly happened. On March 3, 2026, at 1:27 PM, V11 (LPN) stated that on January 30, 2026, at around 12:30 PM, she was informed by V12 (facility caregiver) that R2 was complaining of knee pain. Upon assessment she noticed that R2 was complaining of pain on the right knee with notable swelling and a little scratch on the skin. R2 scored her pain as 4/10 (10 being the worst). V11 stated that when she interviewed R2, the resident stated that she fell out of bed and when she re-interviewed R2, the resident changed her response and stated that she did not fall but she hit her knee. According to V11, R2 was not able to say where or what she hit her knee with. Per V11, she called R2's physician and informed of the pain and swelling on R2's right knee and gave the order for a stat x-ray, but because of the snowstorm, the x-ray company cannot perform the ordered procedure, so R2 was eventually sent out to the hospital with husband's approval. According to V11 she asked V12 what happened, and she was informed that R2 did not fell but V12 claimed that she applied R2's full body mechanical lift pad under the resident and while attempting to attach/hook the lift pad to the mechanical lift bar, R2 hit her right knee on the mechanical lift bar. V11 stated that she had V12 demonstrate the incident and revealed that while the full body mechanical lift bar was placed over R2 to attach the lift pad, it was positioned too low that when she was attaching the lift pad to the lift bar, R2 hit her right knee on the lift		S9999				

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S9999	Continued from page 7 bar. V12 admitted to her that she applied the lift pad under R2 and attached/hooked R2 to the mechanical lift by herself without the second staff present to assist and guide. During the same interview, V11 stated that per facility's policy and in-service training, two staff should always be present during the entire transfer procedure, starting from applying the lift pad under the resident, attaching/hooks the lift pad to the mechanical lift, transferring the resident and positioning the resident to either the bed or the chair, because both staff can check that resident's body parts are free from accidental injury by way of hitting on surfaces and to ensure resident safety during the transfer. On March 3, 2026, at 12:56 PM, V3 (ADON) stated she believes that R2 sustained the fracture on the right femoral shaft because V12 (facility caregiver) assisted the resident by herself, causing R2 to hit her right knee on the mechanical lift. The facility's policy and procedure regarding total mechanical transfer last revised on September 17, 2025, showed in-part under the purpose, "To safely transfer residents who per the Safe Patient Handling & Mobility (SPHM) program and plan of care, require the use of a total mechanical lift." The same policy under the procedure showed in-part, "2. The total mechanical lift must have two staff members present. Staff member may include nurses, aides, PT (Physical Therapist) and OT (Occupational Therapist)." The facility's full body mechanical transfer lift procedure being used by the facility to train aids showed that as part of the set-up, two caregivers must be present, one on each side of the resident's bed, before placing the lift pad (sling) under the resident. The procedure showed that the two caregivers would apply the lift pad to make sure that the resident is squarely centered and then the aide would roll the mechanical lift to the side of the resident's bed, open the base of the lift to its widest point, then place the base under the bed so that the guide handles are next to the bed and the overhead bar of the lift is directly over the resident. Then "the second caregiver grabs the bar as the lift is lowered so it does not strike the resident." 2. R1 had multiple diagnoses including Meniere's disease, scoliosis and osteoporosis, based on the diagnosis sheet. R1's service plan assessment dated October 24, 2025,			S9999			

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S9999	Continued from page 8 showed that the resident was oriented. The service plan assessment documented that R1 "requires assist of mechanical lift (total lift) with two staff assist" with transfer. The same service plan assessment showed R1's level of care was, "5" which meant the resident required two-person maximum assistance with all ADLs (activities of daily living). R1's active service plan report (care plan) initiated on November 1, 2024, showed that the resident has an ADL self-care deficit. The same service plan report showed multiple interventions including, "Transfer: She requires assistance with [full body mechanical lift] transfer with 2 care team members. Provide direction by using short, simple instructions. Provide her with step-by-step guidance during transfer process, encouraging her participation as much as possible." This intervention was initiated on September 25, 2025. Progress notes dated January 19, 2026, at 2:48 PM created by V5 (LPN/Licensed Practical Nurse) showed, "CNA (Certified Nursing Assistant) notified the nurse via radio to come to the resident's room. Upon arrival nurse observed the resident active bleeding from the head. Immediate assessment was performed. CNA reported that during transfer of the resident from wheelchair to bed using the [full body mechanical] lift the sling became caught on the [full body mechanical lift]. Staff safely lowered the resident, during which the resident bumped her head on the bed board. Bleeding was noted to the head area. Vital signs obtained and due to head injury, resident sent to ER (emergency room) for further evaluation. [Physician], DON (Director of Nursing), and POA (Power of Attorney) informed. Resident was alert and oriented no signs of distress noted during transfer." R1's initial incident report submitted to the State Regulatory agency on January 20, 2026, showed that on January 19, 2026, at 10:10 AM, "two staff members were transferring [R1] from wheelchair to bed using the [full body mechanical] lift with full body sling, the sling became caught on the frame during lowering. Staff adjusted sling and resident's head came in contact with the top of the bed. Transfer stopped immediately and resident safely positioned. Resident noted to have a skin opening to right side of head. First aid applied. [Physician] contacted and gave orders for resident to be sent out to hospital for further evaluation." R1's final incident report submitted to the State Regulatory agency on January 23, 2026, showed that on January 19, 2026, at 11:00 AM, the full body mechanical lift and sling were checked, and no malfunctions or		S9999				

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S9999	Continued from page 9 defects were noted by the facility. On January 19, 2026, at approximately 1:30 PM, R1 returned to the facility from the hospital with two staples to lacerations on right side of head. On March 2, 2026, at 12:48 PM, R1 was sitting in her wheelchair inside the front office. R1 was verbally responsive but was not able to describe the incident that caused her to have laceration on her head. On March 2, 2026, at 12:57 PM, V4 (CNA) stated she was not the assigned staff for R1 on January 19, 2026, but she assisted V6 (CNA) with transferring the resident from wheelchair to bed using the full body mechanical lift before lunch at approximately 11:00 AM. According to V4, during the transfer she was positioned on the left side of R1 while V6 was on the right side. While lowering R1 to the bed using the full body mechanical lift, the lift bar where the lift pad (sling) was attached got stuck and in the process of repositioning the lift bar, R1's right side of the head hit the headboard of the bed and bleeding immediately occurred. V4 stated that they (V4 and V6) immediately called V5 (LPN) using the two-way radio to come over to R1's room. On March 2, 2026, at 12:26 PM, V5 (LPN) stated that she was the nurse assigned to R1 on January 19, 2026. V5 stated that approximately 10:00 AM, she received a call via the two-way radio to come to R1's room because the resident was bleeding on the head. Upon entering R1's room, the resident was lying in bed with bleeding on the right side of the head due to laceration. According to the two CNAs (V4 and V6), they were transferring R1 using the full body mechanical lift from wheelchair to bed. Both CNAs informed her that the lift pad got caught on the mechanical lift bar, but they were able to get it working properly. Then in the process of lowering the resident to the bed, R1's right side of the head hit the headboard of the bed. V5 stated that she immediately called 911 to transfer R1 to the hospital due to the bleeding on the head. V5 stated that R1 returned to the facility the same day during her shift with two staples on the right side of the head. On March 3, 2026, at 12:10 PM, V6 (CNA) stated that she was the assigned staff for R1 on January 19, 2026. On the said date sometime after lunch (between 12:30 PM and 1:00 PM) with the assistance of V4 (CNA) they transferred R1 from the wheelchair to bed using the full body mechanical lift. According to V6 she was positioned on the right side of R1, while V4 was on the left side of the resident. During the transfer process,		S9999				

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058602		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/05/2026	
NAME OF PROVIDER OR SUPPLIER EDEN VISTA BURR RIDGE				STREET ADDRESS, CITY, STATE, ZIP CODE 6801 HIGHGROVE BOULEVARD , BURR RIDGE, Illinois, 60527			
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S9999	Continued from page 10 the lift bar got stuck and after repositing the lift bar, they were able to get the lift working. While lowering R1 to the bed, the resident's right side of the head hit the bed headboard that caused a skin breakdown. V6 stated that after lying R1 in bed, they immediately called V5 (LPN) via the two-way radio to come to R1's room to check the resident. During the interview, V6 stated, "I think we put her down too close to the headboard." During the same interview, V6 stated that she had received an in-service regarding mechanical lift transfer, prior to the January 19, 2026, incident with R1. According to V6, the in-service included ensuring that before lowering and putting the resident in the bed, the resident's head and any other part of the body should be cleared from hitting any object to ensure safe transfer and prevent accident. V6 commented, "we mess up." On March 3, 2026, at 12:48 PM, V9 (OT) stated that when lowering the resident while in a mechanical lift, the staff are expected to guide the resident's body for appropriate placement either on the chair or on the bed to ensure good clearing of the head and other body parts to prevent the resident from hitting any object or surface. On March 2, 2026, at 1:47 PM, V3 (Assistant Director of Nursing) stated that she investigated R1's incident that occurred on January 19, 2026. According to V3, based on the investigation the cause of R1 hitting her head on the bed headboard was due to CNA error because both CNAs (V4 and V6) did not check for clearing to make sure R1 could be safely lowered to the bed without hitting her head, while using the full body mechanical lift. V3 added, "My staff was in the wrong" which caused R1 to have laceration on the head requiring staples. The facility's policy and procedure regarding total mechanical transfer last revised on September 17, 2025, does not address strategies and steps to transfer a resident from the chair to the bed safely using a mechanical lift. On March 4, 2026, at 1:08 PM, V3 (ADON) stated that she had reviewed the same policy and procedure and confirmed that the current policy does not include strategies and steps to safely transfer a resident from chair to bed using a mechanical lift. (A)			S9999			