

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2025
NAME OF PROVIDER OR SUPPLIER Pavilion of Bridgeview, The		STREET ADDRESS, CITY, STATE, ZIP CODE 8100 South Harlem Avenue Bridgeview, IL 60455	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to ensure that food kept in the refrigerator was labeled with open and use by date to prevent food borne illness and failed to ensure kitchen staff beards and hair were covered with required hair net and beard guard. This failure has the potential to affect 128 residents. Findings include: On 9/29/2025 between 10:04am to 10:10am, during kitchen observation with V10, Dietary Manager, 2 quarter pans of pureed eggs dated 09/26/25 not specifying whether it is open date or used by date. V10 stated it is pureed eggs, and it does not have a used by date. I (V10) cannot see a used by date that must be the prepared date. V10 stated the cook should have put the used by date to show that this is the prepared date. During the same observation 1/2 quart eggs dated 9/28/25 not specifying whether it is open date or used by date. V11, Dietary Aide observed with long beard without beard guards or hair net. V10 stated that all hair should be covered with hair nets and beard guard. Facility policy Hair Restraints/Jewelry/Nail Polish documents in part that food and nutrition services shall wear hair restraints and beard guards. Procedure listed includes but not limited to beard guards or masks will be worn as indicated. Facility policy on Labeling and Dating Foods dated presented dated 2017 documented in part that to decrease the risk of food borne illness and provide highest quality, foods is labeled with and the date by which the item should be discarded dates opened. Facility policy on Storage of Refrigerated Foods from food and nutrition services with revised date 2017 documented in part that refrigerated food is stored in a manner that ensures food safety and preservation of nutritive value and quality. Listed procedure includes but not limited to food in the refrigerator should be labelled with use by date		

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
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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview and record review, the facility failed to clean and maintain the dryer lint screens thoroughly to provide a safe environment for the residents. This failure has the potential to affect all 131 residents at the facility. Findings include: Facility census, dated 12/01/25, documents 131 residents residing at the facility. On 12/02/2025 at 12:20pm, during a tour of the laundry area with V9 (Housekeeping Manager), 4 dryers were observed. V9 opened the lint compartment of dryer #4. The lint compartment floor had a large amount of loose lint on the floor and the lint screen was fully covered with lint. Dryer #3 had a sign stating that the dryer did not work and V9 confirmed that dryer#3 was not working properly and not in use. V9 opened the lint compartment of dryer #2. The lint compartment floor had loose lint on the floor and the lint screen was fully covered with lint. V9 opened the lint compartment of dryer #1. The lint compartment floor had a large amount of loose lint on the floor and the lint screen was fully covered with lint. V9 said, These (lint compartments) obviously have not been cleaned recently. They (lint screens/compartments) are cleaned out every 2 hours. When asked the purpose of cleaning the lint compartments of the dryers, V9 replied, It can cause a fire and burn the place. Record review of facility document titled, Lint Screen Cleaning/Drain Cleaning, undated, documents, in part, All Laundry personnel should be trained to clean lint screens in dryers. These screens will eventually be covered with lint and must be cleaned. If not cleaned, the screens will prevent air from circulating through the dryers and is a definite fire hazard. After every 2 to 3 loads: Shut off dryer, remove lint screen from bottom of dryer, brush off all lint from screen, replace screen in dryer. Record review of the Illinois Long-Term Care Ombudsman Program Residents' Rights for People in Long-Term Care Facilities, revised date 11/18, documents, in part, . Your facility must provide services to keep your physical and mental health, at their highest practical levels. Your facility must be safe, clean, comfortable, and homelike. Record review of facility job description titled, Laundry Aide, undated, documents, in part Maintains all laundry equipment and informs facility's manager as to any maintenance needs.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow policy and procedure and failed to use and follow a valid PRN (as-needed) order for four residents (R9, R39, R122, and R147) receiving psychotropic medications, as required by federal regulations and facility policy. These failures affected 4 residents (R9, R39, R122, and R147) in a sample of 57 residents reviewed for psychotropic medications. Findings include: R9 's medical record showed that R9 was admitted to the facility [DATE] with diagnosis list that includes but not limited to Chronic obstructive pulmonary disease, type 2 diabetes mellitus with ketoacidosis without coma, delusional disorder, restlessness and agitation, major depressive disorder, and retention of urine. On hospice care. R9's MDS (Minimum Data Set) dated [DATE] scored BIMS (Brief Interview for Mental Status) at 03 indicating at R9 is cognitively impaired. Section E coded 0 for behavior R9's medical record MAR (Medication Administration Record) E-POS (Electronic Physician Order Sheet) showed order dated [DATE] for Ativan (Lorazepam) powder apply to skin &ndash; wrist topically every 4hours as needed for agitation, anxiety gel. Give 0.5ml (Milliliter) (0.25mg). This order does not have stop date as required by federal regulation. On [DATE] R9 has another order for Ativan (Lorazepam) oral concentration 2mg/ml. give 0.5ml by mouth every 4hours as needed for anxiety 0.5ml every 4hours PRN. This order does not have stop date as required by federal regulation. On [DATE] R9 to Ativan solution 2mg/ml inject 0.5mg intramuscularly every 8hours as needed for anxious. This order does not have stop date as required by federal regulation. R9s medical record MAR showed documentation that Ativan is being administered without order clarification regarding stop date. On [DATE] between 12:40pm and 12:47pm, V26 RN (Registered Nurse/Hospice case manager) stated in part that (R9) has two orders of PRN (as needed) Ativan used for Restlessness and Agitation orders are to administered sublingual and the other one is rubbed on the skin if she can't take it sublingually. When surveyor asked about stop date for antipsychotic medications used as PRN, V26 stated, we don't use a stop date; we are unable to gauge the dying date/transition date. The medication is use for symptoms management. Regarding 14 days stop date and re-assessment we don't use stop date, that must be something with (for) the facility. When asked about the policy on the care provider decision not adhering to federal regulation on this matter, V25 stated that we don't have any policy regarding that. But I will check and send the policy to the administrator (V1) but let me check with my supervisor. On [DATE] at 2:03pm, V26 (RN/Registered Nurse Hospice Case Manager) said, A 14-day period is the candidate timeframe for a GDR (gradual dose reduction), and the resident's symptoms are documented every week. We (hospice staff) hold a weekly IDG (Interdisciplinary Group) meeting during which we discuss the patient and the patient's needs. We do not send documentation to the facility. The IDG includes our (hospice company) doctors and social workers, but it does not include (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	any staff from the facility (resident's facility). The facility communicates with us (hospice) directly. I (V26) come in personally and speak with the facility nurses and with the resident's family. The symptoms are ongoing because we are managing them every week, so we (hospice staff) don't renew PRN (as needed) psychotropic medications every 14 days. A nonpharmacological approach to her (resident) demands was put in place first. For myself, this includes being present with her, sitting and talking with her, talking about her son who passed away, talking about baseball, and anything that helps calm her down. Activities such as folding Kleenex and towels are also used. The facility staff should be doing these interventions as well, although I cannot speak to their nonpharmacological approaches. Because we (hospice staff) complete the IDG without facility staff present, we obtain the plan of care, provide the updated plan of care, and place it in the binder. It (having facility staff present) would not hurt to involve the facility more directly and attend the IDGs. When we (hospice) come to the table and speak with the medical director, the facility is seeing and reporting what they observe and report back to us (hospice staff). It does not sound like a bad idea. The policy titled Hospice Care for Nursing Facility Residents-Psychotropic Medications presented documents that care hospice follows skilled nursing facility regulations related to psychotropic medications for hospice patients that reside in a nursing facility. Psychotropic Medication includes but not limited to anti-psychotics, anti-depressants, anti-anxiety, and hypnotics. Procedure listed includes but not limited to there is a 14-day limit on all PRN (As needed) orders for psychotropic medications. R39's face sheet documents diagnoses' that include, but are not limited to anxiety disorder, dementia, and Alzheimer's Disease. R39's physician order, ordered date: [DATE]; end date: indefinite, documents, in part, Ativan Oral Tablet 1 MG (Lorazepam), Controlled Drug, Give 1 mg by mouth every 6 hours as needed for agitation; Medication Class: Antianxiety Agents; For (Indication for Use): Agitation. This order does not have a stop date as required by federal regulation. R122's face sheet documents diagnoses' that include but are not limited to anxiety disorder. R122's physician order, ordered date; end date: indefinite, documents, in part, hydroxyzine Pamoate Capsule 25 MG: Give 1 capsule by mouth every 6 hours as needed for Anxiety related to anxiety disorder, unspecified (F41.9) 25mg cap every 6hrs as needed.; Medication Class: Antianxiety Agents; Related diagnoses: Anxiety disorder. This order does not have a stop date as required by federal regulation. R147's face sheet documents diagnoses' that include but are not limited to repeated falls and weakness. R147's physician order, ordered date [DATE]; end date: indefinite, documents, in part, hydroxyzine HCl Oral Tablet 25 MG (Hydroxyzine HCl); Give 25 mg by mouth every 8 hours as needed for Anxiety; Medication Class: Antianxiety Agents; Chemicals; Indication for Use: Anxiety. This order does not have a stop date as required by federal regulation. On [DATE] at 11:00am, V28 (RN/Registered Nurse/Care Plan Coordinator/Psychotropic Nurse) said, A 14-day period is the facility policy for the use of PRN (as needed) psychotropics. Examples of psychotropic medications include Seroquel, Trazodone, Clonidine, Lexapro, Hydroxyzine, and Xanax. (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The rationale is that they need to be re-evaluated to see if the medication is affecting the resident, and whether it (psychotropic medication) is still necessary. I (V28) don't know why they (staff) would be documenting a zero on the behavioral sheets and still giving the medication (psychotropic medication). Zero means the resident has no behaviors. Regarding hospice, when giving Ativan PRN, the policy does not exclude hospice residents. Generally, Ativan is used for end-of-life care. When you need it, you need it, such as when they (residents) are having respiratory distress or agonal breathing. We (facility staff) are supposed to follow our policy. In my (V28) professional opinion, it depends on the hospice patient and the orders. Some residents are on Ativan and never use it; sometimes they (residents) use it within 14 days. Based on facility policy, it (PRN psychotropic medication for residents on hospice) should still follow the same procedure. The correct indication for use should be listed in the diagnosis of the resident. Regarding how we (facility staff) monitor per CMS regulations: for new patients, I (V28) make the NP (nurse practitioner) psych aware and ensure diagnoses are present, identify what the target behaviors are, and ensure tracking based on ancillary orders and nurses entering the information into the EMAR (electronic medical admission record). We (facility staff) do GDRs (gradual dose reductions). Pharmacy sends over the list of who is due for a GDR. The Psych NP oversees it. Sometimes we attempt a GDR and are not successful, and sometimes we do not attempt it at all. It's (R147's hydroxyzine order) discontinued now. R147's order (hydroxyzine order) was put in wrong. Her (R147) brother died and should have been a one-time dose. The black box warning for psychotropic medications lets us know that this medication can be a danger for certain residents. When asked which certain residents, V28 replied, Most of the population here (residents residing at the facility). On [DATE] at 1:47pm, V3 (Director of Nursing/DON) said, Psychotropic PRN (as needed) medications are ordered for 2 weeks or 14 days to be reevaluated. The purpose is to see if the resident still needs the medication, check resident behaviors if worse or better. Record review of facility's Informed Consent For Psychotropic Medication, undated, documents, in part, Antianxiety drugs: Purpose: To reduce anxiety that impedes normal functioning, drug may be used as an antiseizure medication or as a muscle relaxant. Possible side effects: Drowsiness, confusion, apathy, fatigue, dizziness, unsteady gait, nausea, vomiting, headache, rash and blurred vision. Record review of facility policy titled, Abuse Prevention Program, dated 10/2022, documents, in part, This (Name of Facility) facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents. This will be done by: establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment; identifying occurrences and patterns of potential mistreatment; assuring that physical restraints are used sparingly and properly, and that chemical restraints are not used. Record review of facility policy titled, Psychotropic Medication, dated 11/2013, documents, in part, Prior to starting a psychoactive drug consider the resident rights: the right to be informed about the resident's condition, treatment options, relative risk and benefits of treatment, required monitoring, expected outcomes, the right to refuse and the right to be free of chemical restraints. All informed (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	consents have a black box warning identifying an increased risk for death in the elderly when using antipsychotic medication. The resident has the right to be free from any physical or chemical restraints imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms. When used as a restraint the facility must use the least restrictive alternative for the least restrictive amount of time and document the ongoing reevaluation of the need for the restraint. The prescribing and administration of psychotropic drugs is based on a comprehensive assessment of the resident. Residents who use psychotropic drugs receive gradual dose reductions, unless clinically contraindicated, and behavioral interventions. Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. Residents must be free of unnecessary drugs. (Unnecessary drugs are any drug when used in excessive dose, excessive duration, without adequate monitoring or without adequate indications for its use or in the presence of adverse consequences which indicate the dose should be reduced or discontinued.) Psychotropic drug is any drug that affects brain activities associated with mental processed and behavior. These drugs include, but are not limited to, drugs in the following categories: Anti&shy;psychotics, anti-depressants, anti-anxiety and hypnotics. Residents do not receive psychotropic drugs pursuant to PRN orders unless that medication is necessary to treat a diagnosed specific condition. PRN orders for psychotropic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for appropriateness of the medication and documents their rationale for continued use in the resident's medical record for the duration of the PRN order. If antipsychotic medications are administered as PRN dosages repeatedly over several days, the Physician should discuss the situation with staff and evaluate the resident as needed to determine whether the use is appropriate, and the symptoms are responding to the medication. Documentation Requirements: 1. An informed consent form signed by the resident or legal representative for the appropriate medication(s) and dose. A new consent will be completed if a dose increases, or a new drug is started. 2.Evaluation and Education of resident and resident representative and documentation of such. 3. An initial and annual Psychoactive Medication Screening, which will include: a. Behaviors exhibited b. Psychiatric diagnosis and/or dementia diagnosis and stage as documented. c. Rule out any transitory conditions that could cause a change in behavior d. Possible causative factors. e. Non-pharmaceutical interventions f. Possible risks/complications. g. Results of Gradual Dose Reduction. h. Justification to proceed or not to proceed. 4. A Psychoactive medication quarterly screening is to be completed at least quarterly. The following information is reviewed and evaluated; a. The residents targeted symptoms and the effect of the medication on the severity, frequency and other characteristics of the symptoms. b. Any changes in the residents' function during the past quarter as identified in the MDS, CAM or physician notes. c. If the resident experienced any psychotropic related adverse consequences during the previous quarter. d. If a reduction was attempted and the outcome. e. If reduction attempt is contraindicated f. The rational for continuing the medication. 5. Episodic behavior intervention charting is completed for each resident receiving psychoactive medication. Orders for the medications must include: e. Reason or problem for which given. 10. Physician's orders not specifying the number of doses, or duration of medication, shall be subject to automatic stop orders. a. To prevent continued administration of potentially hazardous medications without appropriate review and authorization, drugs not specifically limited to duration of use and number of doses when ordered will be controlled by automatic stop orders. b. One (1) day prior to the date the stop order is to become effective, the Nurse on duty must contact the Attending Physician to determine if the medication is to be continued. Record review of the Illinois Long-Term Care Ombudsman Program Residents' Rights for People in Long-Term Care Facilities, revised date 11/18, documents, in part, . Your facility must provide services to keep your physical and mental health, at their highest practical levels. Your facility must be safe, clean, comfortable, and homelike.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure preadmission screening assessments were completed as required for residents identified that have a mental illness. This failure affected four residents (R4, R5, R59, and R124) reviewed for pre-admission screening in the sample list of 57 residents. Findings include: R4 is [AGE] years old and have resided at the facility since 2021, past medical history include, but not limited to pot traumatic stress disorder, bipolar disorder current episode mixed, unspecified, major depressive disorder recurrent, unspecified, type 2 diabetes, etc. R4 has an MDS indicator for no PASARR 11 with diagnosis of post-traumatic stress disorder (PTSD), bipolar disorder and major depressive disorder. On 12/03/2025 at 9:30AM, requested resident's PASRR screening from the facility and they provided a copy of Federal Omnibus Budget Reconciliation Act (OBRA) pre-admission screening dated 01/03/2021. Surveyor requested for resident's PASARR screening from Maximus and V2 (Assistant Administrator) said that they do not have any screening from Maximus for the resident. R5's face sheet documents an admission date of 1/03/2025 with diagnoses that include but are not limited to hypomanic bipolar disorder (onset date 1/03/2025), depressed bipolar disorder (onset date 1/03/2025), major depressive disorder (onset date 1/03/2025), anxiety disorder (onset date 1/03/2025), mood (affective) disorder (onset date 1/03/2025), and unspecified mental disorder due to known physiological condition (onset date 1/03/2025). R5's Notice of PASRR (Pre-admission Screening and Resident Review) Level I Screen Outcome, dated 11/29/2024, documents, in part, PASRR Level I Determination: No Level II Required &dash; No SMI (Serious Mental Illness). Evidence shows that R5's PASARR Level I Screen is inaccurate due to R5 having multiple mental Illness diagnoses including, but not limited to bipolar, depression, and anxiety disorder. Review of R5's health records do not show that a Level II Pre-admission Screening and Resident Review (PASARR) was completed for R5 even though R5 has multiple mental health diagnoses that include hypomanic bipolar disorder, depressed bipolar disorder, major depressive disorder, and anxiety disorder. R59's face sheet documents an admission date of 4/27/2021 with diagnoses that include but are not limited to anxiety disorder (onset date 5/20/2023), mood disorder (onset date 3/29/2023), depressive disorder (onset date 08/01/2021), and psychosis (onset date 4/27/2021). R59's OBRA-1 INITIAL SCREEN, dated 4/23/2021, documents, in part, Reasonable Basis To Suspect A Mental Illness: 1) The individual has been diagnosed with a mental illness verified by a DSM IV classification: No.; There are other indicators of mental health: No. Review of R59's health records do not show that a Level I or Level II Pre-admission Screening and Resident Review (PASARR) was completed for R59 even though R59 has mental health diagnoses that include anxiety disorder and depressive disorder. (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R124 is [AGE] years of age. Current diagnoses include but are not limited to Dementia with other behavioral disturbance, Other Specified Depressive Episodes, Generalized Anxiety Disorder, and Other Psychotic Disorder Not Due To A Substance or Known Physiological Condition. R124 was admitted to the facility on [DATE]. R124's comprehensive assessment dated [DATE] section C cognitive patterns documents a brief interview for mental status with a score of 14 out of 15. R124 is cognitively intact. On 12/03/2025 at 9:30 AM, V2 Assistant Administrator was inquired of PASARR (pre-admission screening and resident review) for residents in the facility for a mental disorder or related condition prior to being admitted . V2 said, We have a liaison at the hospital that does the screening. All the residents have to be screened. Can you explain what you mean by through Maximus? I'd have to check with Social Service. V2 provided R124's OBRA (Federal Omnibus Budget Reconciliation Act) pre-admission screening from 11/21/2018. On 12/3/25 at 12:06pm, V2 (Assistant Administrator) said, We (facility) receive the referral of the patient from the hospital prior to admission. Once the patient arrives here, we enter the information into MAXIMUS. If the PASARR form has not been completed before admission, Social Services requests it. The purpose of the PASARR is to make sure the individual is appropriate for nursing home placement and does not require a Level II evaluation. A Level II is the second level of screening. I (V2) do not request PASARR's to be completed, Social Services gets involved for PASARR requests. On 12/03/25 at 12:14pm, V25 (Social Services Director) said, When the patient comes here, we (facility staff) confirm that a PASARR has been completed when it is triggered. Admissions reviews the information and looks at the face sheet to identify any mental health diagnoses that would trigger the process. If the PASARR has not been completed, I (V25) go in and request the clinical information to determine if the patient is appropriate for a SNF (skilled nursing facility) based on the clinical packet. I (V25) would then initiate the PASARR and determine whether someone from MAXIMUS needs to come in to assess for a Level II. The purpose of the Level II is to determine whether the patient's psychiatric diagnosis is appropriate for our setting or if they require placement in another level of care. Examples of mental health or psychiatric diagnoses that may trigger the process include paranoid schizophrenia, bipolar disorder, major depressive disorder, delusional disorder, multiple personality disorder, and anxiety. On 12/3/25 at 12:31pm, V2 (Assistant Administrator) said, I (V2) review the PASARRs for the potential new residents to be admitted . I (V2) do not have any clinical experience. Record review of facility policy titled, admission Criteria, revised date 11/2020, documents, in part, Nursing and medical needs of individuals with mental disorders or intellectual disabilities will be determined by coordination with the Medicaid Pre-admission Screening and Resident Review program (PASARR) to the extent practicable. Pamphlet titled, Illinois Long-Term Care Ombudsman Program Residents' Rights for People in Long-Term Care Facilities, revised date 11/18, documents, in part, . Your facility must provide services to keep your physical and mental health, at their highest practical levels.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 ensure that chemical sprays were safely locked up when not in use by authorized facility staff to prevent accidental use by residents with diagnosis that includes respiratory disease/compromise for five of five residents (R9, R21, R66, R70, R117) reviewed for hazards and supervision. This failure affected five of five residents (R9, R21, R66, R70, R117) and has the potential to affect all 43 residents residing on the 2nd floor of the facility. Findings include: R9's medical record showed that R9 was admitted to the facility 04/09/2024 with diagnosis list that includes but not limited to Chronic obstructive pulmonary disease, type 2 diabetes mellitus with ketoacidosis without coma, delusional disorder, restlessness and agitation, major depressive disorder, and retention of urine. R21's medical record admission record showed that R21 was admitted [DATE] with listed diagnosis that includes but not limited to Chronic obstructive disease, type 2 diabetes mellitus without complications, major depressive disorder recurrent, unspecified asthma, and localized edema. R66 medical record admission Record showed that R66 was admitted on [DATE] with diagnosis information list that includes Acute respiratory failure and hypoxia, chronic obstructive pulmonary disease, and pain in left knee. R70's admission record showed that E70 was admitted to the facility on [DATE]. Listed diagnosis includes but not limited to unspecified Chronic bronchitis, hemiplegia unspecified affecting right dominant side, major depressive disorder recurrent and weakness. R117 medical record admission Record documented that R117 was admitted [DATE] and with diagnosis information list that includes but not limited to Interstitial pulmonary disease, major depressive disorder recurrent, and anxiety. On 09/29/2025 at 10:31am, R21 observed sitting in wheelchair. Disinfectant spray was observed on the dresser. R21 stated in part she uses it whenever her roommate (R70) or self (R21) pooped or there is a smell in the room. R21's diagnosis includes COPD (Chronic Obstructive Pulmonary Disease includes but not limited. R70 has a diagnosis list that includes respiratory problem Bronchitis. V6 Registered Nurse (RN) then stated she (R21) should not be spraying that in the room. On 9/29/2025 at 11:16am, V3 DON (Director of Nurse's) stated in part the expectation of staff in making rounds, includes making sure any hazardous chemical in use in this case Lysol disinfectant spray are not stored inappropriately. On 9/29/2025 at approximately 11:44am, V9, Housekeeping Manager stated, the facility don't use this type of disinfectant product, (R21) must have bought it (on-line store). The disinfectant spray has caution information to keeps out of reach of children with physical hazard that it is flammable, hazard to humans and Domestic humans. On 09/29/2025 between 11:45am to 11:47am, V8 CNA (Certified Nurse's Aide) stated in part that rounds are made every two hours and if medications are left at bedside typically tell the nurse. I (V8) was so busy today, I did not recall. She (R21) usually has lots of things at her bed side on the table. The room is a little bit darker, I (V8) did not see any (disinfectant), If I see it, I will take it because I don't think she should have it. On 09/30/2025 at 12:34pm, R9 observed in bed in a low position, responds to name call. On R9 dresser at the bedside a can of odor neutralizer observed on the dresser in the room with danger information that stated extremely flammable aerosol with instruction to keep out of reach of children. On 09/30/2025 at approximately 12:42pm, V17 (LPN) was shown the aerosol. V17 stated in part that the family brought it for the resident, and we (staff) have told them many times not to. V17 stated that R9 is a hospice patient, and I (V17) think she has diagnosis of COPD. R9 diagnosis list includes but not limited to COPD (Chronic Obstructive Disease). On 9/30/2025 between 12:49pm to 12:51pm, V20 ADON (Assistant Director of Nurses) was made aware of this observation. V20 stated that no chemical like aerosol should be used by the resident especially if they have a roommate. On 12/02/2025 at approximately 10:02am during R9's wound care observation with V24 (Wound Care Nurse). One can of lemon air freshener left at R9's bedside table. When this was shown to V24, V24 stated this should (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not be stored at bedside but not to give any excuse at times the family members bring them (Air freshener) into the building (Facility).On 12/02/2025 at 10:16am, when this was shown to V20 ADON (Assistant Director of Nurse's) and V13 RN (registered Nurse) was shown the air freshener, they both stated that it should not be at bedside. V13 stated I did not realize that it was there the family must have brought it for her.On 12/2/2025 at approximately10:25am, observed from the hallway on the windowsill of R66 and R117's room one can of air freshener and a can of insecticide (OFF). R117 observed with oxygen in use. On 12/2/2025 at approximately 10:26am, V19 RN (Registered Nurse) was shown the two cans, and she stated that R117 is not supposed to have those. Any resident with respiratory issue she should not be spraying that around them. R117 then stated, they are mine and I used them. V19 told R117 that she is not supposed to have it at bedside. Review of R66 roommate to R117 showed listed diagnosis that includes but not limited to Acute respiratory failure and hypoxia, chronic obstructive pulmonary disease.On 12/2/2025 at approximately 11:51am, V3 (DON) stated that the rationale for not keeping the air freshener products at bedside is to prevent aerosols in the air that can affect those residents with respiratory problem like Asthma or COPD. The facility policy titled Hazardous Materials and Waste Storage with no date documented in part that the purpose of the policy is that the facility shall ensure that hazardous materials and waste are stored in a safe manner to prevent injury to residents, visitors and staff. All hazardous materials shall be received into the facility by appropriate staff and stored in a supply room closet for chemicals only.Facility Safety and Supervision of Resident policy presented with no date documents in part that under the policy statement that facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to properly document medication administration of controlled medications on the controlled drug receipt/record/disposition form for three residents (R32, R63, and R140) and failed to properly document shift change accountability on the controlled substances check form per facility policy. These failures have the potential to affect 22 residents on 2nd, 18 residents on 3rd, and 15 residents on 4th floor that receive controlled medications reviewed during medication storage review. Findings include: On 09/29/2025 at 10:42 AM, the 4 [NAME] medication cart was reviewed with V12 LPN. The shift change accountability for controlled substances record has missing nurse initials for 09/21/25 on 2nd and 3rd shift. R140's controlled drug receipt record/disposition form documents Hydrocodone-Acetaminophen *Controlled Drug* Oral Tablet 5-325 mg (milligrams) give 1 tablet by mouth every 8 hours as needed for pain. Review of R140's controlled drug receipt record/disposition form documents 15 tabs remain. The count of the medication card identified 14 tabs remained in the package. V12 said, I gave it at 9 AM, I was going to sign it out. The 09/29/2025 9AM dose of Hydrocodone was not documented as administered by V12 on the controlled drug form. On 09/29/2025 at 10:45 AM, R140's controlled drug receipt record/disposition form documents Alprazolam Oral Tablet 0.25 MG *Controlled Drug* give 1 tablet by mouth one time a day related to Anxiety Disorder. Review of R140's controlled drug receipt record/disposition form documents 25 tablets remain. The count of the medication card identified 24 tablets remain. V12 said, I forgot to sign it this morning. The 09/29/2025 9AM dose of Alprazolam was not documented as administered by V12 on the controlled drug form. On 09/29/25 at 10:54 AM, the 4 East medication cart was reviewed with V13 RN Registered Nurse. R32's controlled medication Tramadol 50mg (milligrams) one tab by mouth every 8 hours prn (as needed) does not have a controlled drug receipt record/disposition form. There is a handwritten paper being used to document the medication. V13 RN was inquired of the paper. V13 said, I'm not sure what happened when it was delivered, this is what everyone has been using. The last documented dose of medication on the handwritten paper states 6/12 (2025). On 09/29/2025 at 11:07 AM, the 3 [NAME] medication cart was reviewed with V23 RN Registered Nurse. The shift change accountability for controlled substances record has missing nurse initials for 09/08/2025 2nd and 3rd shift, 09/11/2025 2nd and 3rd shift, 09/27/2025 2nd and 3rd shift, and 09/28/2025 1st, 2nd, and 3rd shifts. On 09/29/2025 at 11:40 AM, the 2 East medication cart was reviewed with V7 RN Registered Nurse. The shift change accountability for controlled substances record has missing nurse initials for 09/05/2025 1st and 2nd shift, 09/11/2025 3rd shift, 09/12/2025 2nd and 3rd shift, 09/13/2025 1st shift, 09/14/2025 3rd shift, 09/15/2025 1st shift, 09/22/2025 3rd shift, 09/23/2025 1st, 2nd, and 3rd shift. On 09/29/2025 at 11:43 AM, R63's controlled drug receipt record/disposition form documents Pregabalin Capsule 75 mg (milligrams) give 1 capsule by mouth one time a day related to other specified Polyneuropathies. Review of R63's controlled drug receipt record/disposition form documents 11 tabs remain. The count of the medication card identified 10 tabs remained in the package. V7 was inquired of the medication. V7 said, She's the only one I haven't signed. The 9AM dose of Pregabalin was not documented as administered by V7 on the controlled drug form. On 09/29/2025 at 2:23 PM, R140's medication administration record documents V12 administered the dose of Hydrocodone related to R140's pain rate of 5 at 09:03 AM. The Xanax dose is documented as administered at 9AM by V12 on the medication administration record. Review of R32's physician orders document her Tramadol was originally ordered on 08/08/2024 and discontinued 07/17/2025. Physician order notes state per pharmacy recommendation; med has not been dispensed. On 09/30/2025 at 12:36 PM, V3 DON (Director of Nursing) was inquired of concerns identified during medication administration. When administering medications and controlled substances, when should it be signed out? V3 said, Document after administration ensuring resident took medication. If not, you'd have to go back and (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	document why it wasn't taken. When the nurse pulls out the narcotic medication from the box it should be checked against the control record and MAR (medication administration record). Take the medication, write remaining amount, and administer it then sign it out. If a medication is received from the pharmacy without a controlled substance accountability record, what should be done? V3 said, We would call the pharmacy and ask them to send a log. If not, we have blank controlled substance records. We would copy the medication on the sheet with another nurse, prescription number, instructions of administration, day received, amount received. They should follow up with me so I can reach out to pharmacy. It's not ok to use a blank sheet of paper. The control log has what we need to be documented. V3 further said, The oncoming and off going nurse should be counting the narcotics together then sign the end and start of shift page. The Nursing Policy and Procedure revised 11/2020 states in part: Policy StatementThe facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Schedule II and other controlled substances. Policy Interpretation and Implementation3. Controlled substances must be counted upon delivery. The nurse receiving the medication, along with the person delivering the medication, must count the controlled substances together. Both individuals must sign the designated controlled substance record.4. If the count is correct, an individual resident controlled substance record must be make for each resident who will be receiving a controlled substance. This record must contain: a. name of the resident, b. name and strength of the medication, c. quantity received, d. number on hand, e. name of physician, f. prescription number, g. name of issuing pharmacy, h. date and time received, i. time of administration, j. method of administration, k. signature of person receiving medication, and l. signature of nurse administering medication.9. Nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing Services. The 3.3 Controlled Substance Policy states in part: PolicyMedications classified by the FDA as controlled substances have high abuse potential and may be subject to special handling, storage, and record keeping.Procedure: 4 b. All schedule II controlled substances (and other schedules if facility policy so dictates) will be counted each shift or whenever there is an exchange of keys between off-going and on-coming licensed nurses. The two nurses will: 1. Inspect both the drug package and the corresponding count sheet to verify the accuracy of the amount remaining. 2. Both nurses will count the number of packages of controlled substances that are being reconciled during the shift/shift count and document on the Shift Controlled Substance Count Sheet. 3. Both nurses will count the Controlled Substances count sheets and verify the accuracy of the number of remaining count sheets. 4. Both nurses will sign the Shift/Shift Controlled Substances Count Sheet acknowledging that the actual count of controlled substances and count sheet matches the quantity documented.he United Rx Pharmacy 5.4 Controlled Substance Medication policy states in part: PolicyMedications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and record keeping in the facility, in accordance with federal and state laws regulations.Procedure: 6. Controlled substances will be dispensed by the pharmacy along with an Individual Charting Record. This record will be maintained by the nursing staff at the time of each administration of the medication as follows: a. place charting record in narcotic box or binder, b. record each dose at the time of administration, c confirm the amount of controlled drug remaining is correct prior to assembling required dose for administration- i. date, ii. Time, iii. Dosage, iv. Signature of nurse who administered dose, v. number of does remaining.V7 RN's Registered Nurse job description dated and signed on 05/22/2024 states in part: Maintains knowledge of necessary documentation requirements. I have reviewed this job description and I understand all my job duties and responsibilities. V12 LPN's Licensed Practical Nurse job description dated and signed on 11/08/2022 states in part: Maintains knowledge of necessary documentation requirements. I have reviewed this job description and I understand all my job duties and responsibilities. V13 RN's Registered Nurse job description dated and signed on 02/17/2023 (continued on next page)		

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Centers for Medicare & Medicaid Services

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	states in part: Maintains knowledge of necessary documentation requirements. I have reviewed this job description and I understand all my job duties and responsibilities.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to 1. ensure a resident had a physician's order to keep a prescribed inhaler at the bedside for one (R21) resident, 2. failed to remove expired stock Loratadine medication and two unlabeled prescription Fluticasone/Salmeterol oral inhalation Diskus from the medication cart. This failure has the potential to affect 43 residents receiving medication on the 2nd and 4 residents (R24, R91, R92, and R124) receiving Loratadine stock medication on the 4th floor during medication storage review. On [DATE] at 10:31am, R21 was sitting in their wheelchair with Fluticasone propionate nasal spray noted on the bedside table with no label no name and not in manufacturer packet and no pharmacy labeled package. R21 stated that it is mine and I (R21) use it all the time. The nurse gave it to me. It's mine. When the surveyor made V6 (Nurse) aware and shown the medication and was asked about the facility policy on medication administration that includes medication been left at bedside. V6 (RN) stated I don't know if she can keep it at bedside, but I will check her orders. Both surveyor and nurse checked the EMAR (Electronic Medication Administration) there was no order to keep at bedside or self-administer any medication. R21 medical record EMAR and Physician order showed R21 has an order fluticasone propionate nasal to be administered 1 (one) spray each nostril one time a day but there was no order to keep at bedside. V6 stated that the facility protocol and policy on medication storage is that medications should be kept in the med cart. V6 stated that she did not give the medication to R21 because it was scheduled for 6am. On [DATE] at approximately 11:16am, V3 (Director of Nurses') stated in part that the resident should be educated and an order to keep medication at bedside should be obtained (from the physician) or NP (Nurse Practitioner) and it is the expectation that staff will make rounds alternating between the licensed staff (RN/LPN) and the C.N.As and correct whatever is not appropriate. As at [DATE] and [DATE] the facility was unable to present any physician order for R21 to self-administer any medication. On [DATE] at approximately 4:38pm, V3 acknowledge that R21 should not have the nasal spray at the bedside without physician order. Findings include: On [DATE] at 10:47 AM, the 4 [NAME] medication cart was reviewed with V12 LPN. Review of the stock medication notes a bottle of Loratadine 10mg (milligram) medication (Antihistamine) 300 tablet bottle is in the medication drawer with an expiration date of 08/25. V12 LPN was inquired of the bottle. V12 said, It says [DATE]. V12 was asked if the bottle was expired. V12 said, Yes. On [DATE] at 11:52 AM, review of the 2 East medication cart identified 2 unlabeled, undated, and unboxed Fluticasone/ Salmeterol oral inhalation powder 500mcg (micrograms)/50 mcg medication Diskus in the 3rd drawer of the cart. V7 was inquired of the medication. V7 said, I'm not sure who they belong to. They weren't in the box. I'll just toss those. On [DATE] at 12:36 PM, V3 DON (Director of Nursing) was inquired of concerns identified during (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication administration. The [DATE] Pharmacy 4.1 Prescription Labels Policy states in part: Policy: Medications are labeled in accordance with State and Federal laws as well as facility requirements. Procedure: 2. Improperly labeled medications should be rejected and returned to United Rx upon delivery. 6. Medications labels are not altered, modified, or marked in any way by nursing personnel. Contents are not transferred from one container to another. Under no circumstances are unattached labels requested or accepted from the pharmacy. Only the pharmacist may place a label on the medication container. The United Rx Pharmacy Medication Administration Guidelines (Long Term Care Facilities) states in part: Ten Guidelines: The Right Medication. Check the expiration date on the medication. The Medication Storage in the Facility policy states in part: Policy: Medications and biological are stored safety, securely, and properly following the manufacturer or supplier recommendations. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Procedures: 14.Outdated, contaminated, or deteriorated drugs and those in containers, which are cracked, soiled or without secure closures will be immediately withdrawn from stock. They will be disposed of according to drug disposal procedures and reordered from the pharmacy if a current order exists. The facility policy on Administering Medications presented with review date11/2020 documents that medications shall be administered in a safe and timely manner and as prescribed. Policy Interpretation and Implementation listed includes but not limited to residents may self-administer their own medications only if the attending physician in conjunction with the interdisciplinary team Care Planning has determined that they have decision-making capacity to do so safely, and resident has successfully completed a competency for self -administration. Facility policy on Storage of Medications and Medical Supplies documented that the facility shall store all drugs and biologicals and medical supplies in a safe, secure and orderly manner. Highlights on medication containers indicated that drugs and biologicals shall be stored in the packaging, containers or other dispensing systems in which they are received. Facility policy on titled Self-Administration of Medication with revised date 4/2017 documents that the resident has the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. Listed policy interpretation and implementation includes but not limited to self-administration medications must be stored in a safe and secure place, which is not accessible by another resident. Staff shall identify and give to the charge nurse any medications found at the bedside that are not authorized for self -administration for return to the family or responsible party. Facility Safety and Supervision of Resident policy presented with no date documents in part that under the policy statement that facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.		

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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 interview and record review, the facility failed to follow their admission criteria policy by failing to ensure that staff obtained information needed for the care of one resident from the attending physician prior to admission, failed to ensure that staff follow their medication administration policy by failing to administer prescribed diabetic medications and failed to notify the physician that medication was not available. This failure affected one (R135) of one resident reviewed for quality of care. R135 was admitted to the facility from the hospital, alert and oriented and was found unresponsive and cold to touch at the facility the following day. Death certificate listed cause of death as hypertension and diabetes mellitus. Findings include: R135 [AGE] years old admitted to the facility on [DATE], face sheet listed the following past medical history among others; type 2 diabetes with hyperglycemia, acute cystitis with hematuria, essential primary hypertension, mixed hyperlipidemia, hypotension unspecified, hyperkalemia, etc. Hospital record dated 9/16/2025 documented active problems of type 2 diabetes, primary hypertension, hyperkalemia, mixed hyperlipidemia, anemia, etc. R135 received the following medications at the hospital among others: insulin lispro (Humalog pen) 1-5units subcutaneously three times a day with meals, insulin lispro (Humalog) pen 1-4 units subcutaneously nightly, etc. Same hospital record documented to continue the following medications: aspirin 81mg tablet, ergocalciferol 1,250ncg (50,000unit) capsule, glyburide 5 mg tablet, Januvia 100mg tablet, lisinopril 10mg tablet, pioglitazone 30mg tablet, simvastatin 40mg tablet. Discharge condition, stale, discharge disposition subacute rehab facility. Physician order dated 9/17/202 listed in part: Actos 30mg, give 1 tablet by mouth one time a day for DM, hold if blood sugar is <70, Atorvastatin 40mg, give 1 tablet by mouth at bedtime for hyperlipidemia, glyburide oral tablet 5mg, give 1 tablet by mouth two times a day, hold if blood sugar is <70, sAxagliptin 5mg tablet, give 1 tablet by mouth one time a day for DM, hold if blood sugar is <70, Sitagliptin phosphate 100mg, give 1 tablet by mouth one time a day for diabetes. Vital sign section of the medical record showed that the only blood sugar documented for the resident was 210, on 9/16/2025 at 21:34. Medication administration record (MAR) for September 2025 showed that R135 did not receive any of the above medications from the time of admission [DATE] at 19:56) to 9/17/2025 at 17:30 when the resident expired at the facility, all staff initialed the MAR with the number 9 indicating medicine was not available. On 12/3/2025 at 3:38PM, V34 (LPN) said that she admitted the resident, did a body assessment on him. V34 said that he received a report from the hospital before resident arrived and they told her that he is diabetic, she also reviewed the hospital record and texted a list of his medication to the doctor who told her to keep the same. V34 said that she did a blood sugar on the resident as a standard for admission, she did not inform the doctor that the resident is diabetic and did not receive any orders for blood glucose check from the doctor. V34 said that she did not give resident any medications that day because it was already late, his medication did not come from pharmacy yet and she did not have access to the emergency medication box. V34 added that there was no other staff on ground with access to the emergency box. V34 added that she did not notify the doctor or DON (Director of Nursing) that resident's medication was not available. Surveyor presented a medication administration record (MAR) where V34 signed that she gave resident atorvastatin 40mg at 21:00 on 9/16/2025 at 2100 and she said, I don't know why I signed, I might have marked it in error. Fire department report dated 9/17/2025 documented in part: crew was dispatched for the full arrest, upon arrival [AGE] year-old male was found unresponsive and pulseless. Nursing home staff stated they found the patient unresponsive and started CPR immediately. Nursing home staff stated the last known well was 40 minutes prior to patient contact. Crew was unable to palpate carotid pulse, crew noted patient was apneic. Crew noted rigor mortis and that patient was cold to touch. A 4 lead EKG was obtained showing asystole, time of death was 17:30. ALS assessment started at 17:18 as documented in the report. Progress note dated 9/17/2025 16:55:00 by V35 (LPN) documented the (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	following: Received patient in bed with HOB elevated, alert, and oriented stated that he is here for therapy, denies any pain or discomfort at this time. VS 98.0-82-18-122/66. 02 saturation 97% blood sugar 177. will continue to monitor.V35 documented on 9/17/2025 at 17:20:00, observed patient pale and cool to touch unable to obtain vital signs and blood sugar, code called 911 called MD, notified. Family friend called and message left to call the facility.On 12/02/2025 at 3:06PM, V9 (LPN) said she was assigned to the resident on day shift on 9/17/2025, V9 does not recall checking resident's blood sugar or administering any medication to resident. Review of medication administration record (MAR) V17 signed her initials with a letter 9 in the medication administration boxes. Surveyor presented this to V17 who said that the letter 9 indicated that the medication was not available. When residents are admitted sometimes it takes a while for their medications to come in. V17 was asked if she notified the physician that the medications are not available or tried to pull them from the emergency box, and she said no.On 12/03/2025 at 4:04PM, V35 (LPN) said that she was assigned to resident on 9/17/2025, when she arrived at work, she went and introduced herself to resident, went back to get her medication cart, gave resident's roommate medication and when she got to resident, she thought he was sleeping, she tried to wake resident up and realized that he was not breathing. Surveyor presented the above documentations to V35 and asked V35 to clarify how a patient can be alert and oriented at 16:55:00 and was unresponsive and cold to touch at 17:50:00 (25 minutes later). V35 said she did not know, maybe her timing was wrong in her progress note.On 12/03/2025 at 10:18AM, V3 Director of Nursing (DON) said that when resident's medications are not available, nurses are supposed to call the doctor to let them, they can also pull the medication from the emergency box, they are also supposed to document the notification in progress note.On 12/3 2025 at 11:28AM, V27, Pharmacist said that they delivered medication for resident on 9/17/2025 at 4:11PM, and he will send the manifest or proof of delivery. V27 added that the facility can call them if they any medication urgently or they can pull the medication from their emergency box. On 12/3/2025 at 1:58PM, V33, Certified Nursing Assistant (CNA) said that she recalls the resident, he refused breakfast and lunch on 9/17/2025, stating that he does not have any appetite. V33 said that she left the lunch tray in resident's room and when she came back, he still did not want the food so V33 removed the tray and reported to the nurse.On 12/4/2025 at 10:18AM, V36, Attending Physician said that he never saw the resident and his nurse practitioner (NP) never saw the resident, he does not recall anything about the resident. V36 said that the resident was just assigned to him, he was not part of resident's care at the hospital, and it usually take him and his team 24 to 48 hours to see a new resident. V36 said that the facility has an in-house NP, maybe they saw the resident. he does not recall anyone calling him for medication reconciliation for the resident. V36 does not know anything about resident's medication not being available and no one contacted him.On 12/4/2025 at 11:56AM, V37 (In-House Nurse Practitioner) said that she has worked at the facility since June 2025, works Monday to Friday from 9:00AM to 2:00PM. V37 said that R135 was admitted in the evening around 8:00PM on 9/16/2025 so she did not see the resident that day. She normally sees the new admissions during the day unless the attending physician or their nurse practitioner already saw the resident. V37 said that she did not see the resident the whole day on 9/17/2025, she does not know why except that she thought that the doctor or his NP saw the resident. By the time she went to see the resident he was no longer there. V37 said that no one called her regarding resident's medication, they will usually reconcile the medication with the attending, but no one notified her the following day that resident's diabetic mediations were not available.admission criteria policy revised 11/2020 states in part that the facility will only admit residents who's medical and nursing care needs can be met. Under policy interpretation and implementation, #5 stated, prior to or at the time of admission, the resident's attending physician must provide the facility with information needed for the immediate care of the resident, including orders covering at least: type of diet, medication orders, including (as necessary) a medical condition or problem associated with each medication and routine car orders to maintain or improve the resident's function until the physician and care planning team can conduct a (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Pavilion of Bridgeview, The		STREET ADDRESS, CITY, STATE, ZIP CODE 8100 South Harlem Avenue Bridgeview, IL 60455	
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	comprehensive assessment and develop a more detailed interdisciplinary care plan. United RX medication administration policy dated July 2024, states in part # 23, if medication is ordered but not present, call the pharmacy or supervisor to obtain medication.		

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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 have a five percent (5%) or lower medication error rate. There were 3 medication errors out of 33 medication opportunities resulting in a 9% medication error rate for 3 (R70, R79, and R129) residents reviewed during medication administration. This failure has the potential to affect all 131 residents in the facility. Findings include: On 09/30/2025 at 08:14 AM V17 LPN Licensed Practical Nurse signed out each medication as administered after preparing the medication prior to them being administered to R70. On 09/30/2025 at 08:30 AM, V17 administered 1 tablet of Senokot S Oral Tablet 8.6-50 mg (milligrams) to R79. R79's physician order states: Give 2 tablet by mouth one time a day for Constipation. On 09/30/2025 at 08:44 AM, V17 prepared R129's Senexon-S Tablet 8.6-50 MG give 2 tablet by mouth every 12 hours for Constipation. V17 only prepared 1 tablet for administration. On 09/30/2025 at 08:46 AM, V17 LPN prepared R129's Metamucil 4 in 1 Fiber Oral Packet (Psyllium) give 1 packet by mouth one time a day for Constipation mix in 8oz of liquid physician's order. V17 removed a container of Psyllium from the stock medication. Upon opening the container, V17 removed a clear plastic medication cup from the inside of the powder medication and scooped out an unmeasured amount and put it into a clear cup. V17 is using her bare hands. V17 was inquired of the amount measured. V17 said, I measured 19 ml's (milliliters), but I think it's too much. V17 poured the powdered medicine back into the clear medication cup from the inside of the container. V17 slowly emptied small amounts of the medication back into the container until she reached 15ml of powder. V17 held the clear medication cup up in the air and informed this surveyor she had measured 15mls of the powder. V17 returned the medication powder back into the cup and diluted it with an unmeasured amount of water. V17 did not verify the amount of Psyllium to be administered due to using a house stock container of the medication and not an individual packet per the physician order. V17 did not accurately measure the powdered Psyllium by holding the medication cup in the air at her eye level. V17 did not measure the amount of water needed to mix the medication per the physician order. On 09/30/2025 at 08:53 AM, V17 only administered 1 tablet of Senexon-S Tablet 8.6-50 mg. R129's physician order states give 2 tablets by mouth every 12 hours for Constipation. On 09/30/2025 at 9:10 AM, V17 LPN (Licensed Practical Nurse) was inquired of the medication administration. Why is it important to check the MAR (medication administration record) and physician orders before administering medication to a resident? V17 said, To make sure I give everything the resident is supposed to get. The house stock Psyllium has a clear medication cup inside the container, how is this a concern during medication administration? V17 said, Because we touch the cup and put it back in the jar. It's spreading germs to other residents. How do you ensure reliability and accuracy when taking measurements? V17 said, Measure and sit it down to make sure it's an accurate amount. When administering medications, when should it be signed out? V17 said, I should do it after I give the medication because if the resident refuses it, I have to chart it. On 09/30/2025 at 12:36 PM, V3 DON (Director of Nursing) was inquired of concerns identified during medication administration. Why is it important to check the MAR (medication administration record) prior to giving the medication? V3 DON said, The meds are ordered by the physician and to give the correct dose. It's the five rights, right person, right route, right medication, right dose, right time. If done that would prevent the error. How do you ensure reliability and accuracy when taking measurements? V3 said, To measure I would set the cup down and look at it eye level. Holding it in hand it could shift. When administering medications when should it be signed out? V3 said, Document after administration ensuring resident took medication. If not, you'd have to go back and document why it wasn't taken. The July 2024 Pharmacy 5.2 Medication Administration Policy states in part: Purpose: To administer all medications safely and appropriately to aid residents to overcome illness, relieve, and prevent symptoms, and help in diagnosis. Procedure: 3. Review the resident's Medication Administration Record (MAR). Read each order entirely. 18. Return to medication cart and document medication administration with initials in (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	appropriate spaces on Medication Administration Record (MAR). The United Rx Pharmacy Medication Administration Guidelines (Long Term Care Facilities) states in part: Ten Guidelines: The Right Medication. Check the expiration date on the medication. Verify each medication against the MAR. The Right Dose. Pay special attention to orders like give 2 tabs, 1/2 tabs etc. The Right Documentation. Sign MAR immediately after administering the medications. V17 LPN's Licensed Practical Nurse job description dated and signed on 06/13/2024 states in part: Maintains knowledge of necessary documentation requirements. I have reviewed this job description and I understand all my job duties and responsibilities. V17 LPN's medication administration competency dated and signed on 06/25/2024 states in part: Type of validation: return demonstration. Safely administers medications- 2. Documents initials in MAR/TAR (treatment administration record) after administration or treatment. V17's glucometer competency dated 06/25/2024 states in part: cleans and understands proper maintenance of glucometer per manufacturer. V17's blood glucose monitoring written competency dated 06/28/2024 states in part: 7. The blood glucose machine must be cleaned after use, using the facility approved disinfectant wipes and allowed to dry. V17 marked true. V17's hand hygiene competency dated 06/25/2024 documents return demonstration: pass.		

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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 follow their policy for infection control related to 1. Failed to clean glucometer after resident use, 2. failed to ensure that reusable equipment (blood pressure cuff/machine) was cleaned between use of residents, 3. failed to perform hand hygiene after removing gloves, and before preparing resident medications, 4. failed to put on gloves to dispense a powder stock medication (used bare hand to dispense), 5. Failed to remove a medication cup (not manufacturer provided) stored inside the stock powder medication. These failures applied to four (R5, R70, R79, and R129) of four residents reviewed during medication administration in the sample of 57 residents. Findings include: On 09/30/2025 at 08:14 AM V17 LPN (Licensed Practical Nurse) signed out each medication as administered after preparing the medication prior to them being administered to R70. 09/30/202508:16 AM, V17 knocked and entered R70's door. V17 moved R70's overbed table and adjusted R70's bed upright then administered her medications. On 09/30/2025 at 08:18 AM, V17 did not wash her hands or perform hand hygiene with hand sanitizer upon leaving the room or before preparing medication for the next resident. On 09/30/2025 at 08:17 AM, V17 LPN knocked and entered R79's room door. V17 performed blood glucose monitoring for R79 which resulted in a reading of 312 mg/dL (milligrams/deciliter). V17 also performed a blood pressure reading with a wrist blood pressure cuff. The blood pressure reading was 136/88, pulse 75. V17 left R79's room, returned to the medication cart, and did not wash her hands or perform hand hygiene with hand sanitizer. V17 did not sanitize the blood glucometer or blood pressure cuff after using the equipment for R79. V17 placed the equipment back on the top of the medication cart. On 09/30/2025 at 08:25 AM, V17 dropped R79's Diltiazem Tablet 60 MG onto the top of the medication cart. V17 picked up the pill and threw it into the garbage can on the cart. V17 said, Oh, let me get that. V17 put on a glove and took the pill out of the garbage can and placed it into the sharps (needle and syringe) disposal container on the medicine cart. V17 removed the glove from her hand and put it into the garbage can. V17 did not wash her hands or perform hand hygiene with hand sanitizer. V17 continued on with preparing R79's insulin and medications. On 09/30/2025 at 08:30 AM, knocked and entered R79's room door. V17 put on a pair of gloves and administered R79's insulin into her Left upper abdomen. V17 removed her gloves and administered R79's oral medications. V17 left R79's room, returned to the medication cart, and did not wash her hands or perform hand hygiene with hand sanitizer. On 09/30/2025 at 08:39 AM, V17 knocked on R5's room door and introduced herself. V17 adjusted R5's over bed table and sat the head of the bed up by pressing the button on the arm of the bed. V17 administered R5's medications. V17 left R5's room, returned to the medication cart, and did not wash her hands or perform hand hygiene with hand sanitizer. On 09/30/2025 at 08:42 AM, V17 took R129's blood pressure with her wrist blood pressure machine. R129's blood pressure reading was 121/68, pulse 79. V17 left R129's room and did not sanitize the blood pressure machine. V17 placed the blood pressure machine onto the top of the medication cart. On 09/30/2025 at 08:46 AM, V17 LPN prepared R129's Metamucil 4 in 1 Fiber Oral Packet (Psyllium) give 1 packet by mouth one time a day for Constipation mix in 8oz of liquid physician's order. V17 removed a container of Psyllium from the stock medication. Upon opening the container, V17 removed a clear plastic medication cup from the inside of the powder medication and scooped out an unmeasured amount and put it into a clear cup. V17 is using her bare hands. V17 was inquired of the amount measured. V17 said, I measured 19 ml's (milliliters), but I think it's too much. V17 poured the powdered medicine back into the clear medication cup from the inside of the container. V17 slowly emptied small amounts of the medication back into the container until she reached 15ml of powder. V17 held the clear medication cup up in the air and informed this surveyor she had measured 15mls of the powder. V17 returned the medication powder back into the cup and diluted it with an unmeasured amount of water. There is an infection control concern due to a clear medication cup being stored inside the medication container. V17 did not perform hand hygiene and put on gloves prior to dispensing the medication from the house stock (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication container causing it to be contaminated. V17 left R129's room, returned to the medication cart, and did not wash her hands or perform hand hygiene with hand sanitizer. On 09/30/2025 at 9:10 AM, V17 LPN was inquired of the medication administration. What should be done by the nurse before preparing medication for the resident? V17 said, I should do hand hygiene, I forgot to do it. It's so we don't pass germs around. When using medical equipment such as a blood pressure machine and a blood glucometer between residents what should be done? V17 said, I could wipe it off with a bleach wipe. I don't have any on my cart. It's so we don't spread things around. When gloves are moved from your hands what should be done and why? V17 said, I should do hand hygiene, it's to prevent spread of germs. On 09/30/2025 at 12:36 PM, V3 DON (Director of Nursing) was inquired of concerns identified during medication administration with infection control. What should be done by the nurse before preparing medication for the resident? V3 said, We should hand wash or use hand sanitizer to prevent the spread of germs. When using medical equipment such as a blood pressure machine and a blood glucometer between residents what should be done? V3 said, Glucometer sanitize in between each resident with a bleach wipe and let it air dry. Blood pressure cuff clean with disinfectant wipe and let dry between residents. When gloves are removed, what should be done? V3 said, Hand washing or use of hand sanitizer to prevent spread of germs for infection control. The revised 03/2020 Handwashing/Hand Hygiene Policy states in part: This facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation 1. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare associated infections. 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 5. Employees must wash their hands for at least 20 seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: d. Before and after performing any invasive procedure (e.g. fingerstick blood sampling), l. Upon and after coming in contact with a resident's intact skin, (e.g. when taking a pulse or blood pressure, and lifting a resident), u. After removing gloves or aprons. 6. In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% ethanol or isopropanol for all the following situations: d. Before preparing or handling medications, j. After removing gloves. 8. The use of gloves does not replace handwashing/hand hygiene. The revised 10/13/17 Policy and Procedure Cleaning/Disinfecting/Maintaining Glucose Meter states in part: The Glucose meters will be disinfected between each resident's use to prevent the spread of microorganisms including blood borne pathogens. Disinfection of the machine will be completed with Clorox Healthcare Bleach Germicidal and Disinfectant Wipes Towelettes. Procedure: Cleaning 1. [NAME] nonsterile gloves. 2. Inspect for blood/debris/dust/line anywhere on the meter. 3. Open the towelette container or package and remove one towelette. 4. Wipe the entire surface of the meter 3 times horizontally and 3 times vertically using one towelette to clean blood and other body fluids. 5. Dispose of the towelette. Disinfecting 6. Obtain a second towelette and wipe the entire surface of the meter 3 times horizontally and 3 times vertically using one towelette to remove blood borne pathogens. The meter must be maintained wet for 1 minute for all bacteria except C-diff. 7. Once the exterior of the glucometer has remained wet for the appropriate contact time, the meter may be wiped dry with a dry cloth. 10. Dispose of the used towelette. 11. Remove gloves. 12. Wash hands. The July 2024 Pharmacy 5.1 Medication Administration Policy states in part: Medications are administered as prescribed, in accordance with good nursing principles and practices and only by persons legally authorized to do so. Tips for safe medication administration 2. Follow good infection control practices. a. Cleanse hands before each medication pass. Cleanse hands when contact is made with a medication. Cleanse hands whenever they are contaminated. You may use an antiseptic foam or gel such as Septisol or All Care. b. Never touch any of the medication with fingers. The Cleaning Disinfection Resident Care Items Equipment policy states in part: Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	current CDC recommendations for disinfection and the OSHA Blood borne Pathogens Standard.PROCEDUREThe following categories are used to distinguish the levels of sterilization/ disinfection necessary for items used in resident care:Non-critical items are those that come in contact with intact skin but not mucous membranes.Non-critical resident-care items include bedpans, blood pressure cuffs, crutches and computers, etc.Most non-critical reusable items can be decontaminated where they are used (as opposed to being transported to a central processing location).Reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment). Single resident-use items are cleaned/disinfected between uses by a single resident and disposed of afterwards (e.g., bedpans, urinals).Durable medical equipment (DME) must be cleaned and disinfected before reuse by another resident.Reusable resident care equipment will be decontaminated and/or sterilized between residents according to manufacturers' instructions.Stethoscope / B/P CuffExamine stethoscope for damages. Report damaged equipment to your supervisor.Select facility EPA approved disinfectant wipe (e.g., ethyl or isopropyl alcohol).Applying firm pressure in a circular motion, use disinfectant wipe to clean stethoscope ear pieces, tubing, diaphragm and bell.Wash and dry your hands thoroughly.Return the stethoscope to its designated storage area.Discard disposable equipment and supplies in designated containers.Clean and disinfect the surface area used to clean the stethoscope.Wash and dry your hands thoroughly.		