

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145420	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/15/2025
NAME OF PROVIDER OR SUPPLIER  Bridgeway Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE  111 East Washington Bensenville, IL 60106	

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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>(continued on next page)</p>

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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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to provide care timely incontinence care. This applies to 4 of 6 residents (R1, R2, R3, R4) reviewed for incontinence care in the sample of 11. The findings include: 1. R1's EMR (Electronic Medical Record) showed R1 was admitted to the facility on [DATE], with multiple diagnoses including unspecified dementia, aphasia, dysphagia with gastrostomy tube status, and conversion disorder with seizures or convulsions. R1's MDS (Minimum Data Set) dated April 29, 2025, showed R1 was severely cognitively impaired and required assistance with ADLs including dependent on staff assistance for bathing, dressing, grooming, toileting, bed mobility, and transfer and was always incontinent of bowel and bladder. R1's incontinence care plan initiated on October 10, 2022, showed to provide R1 with incontinence care every 2 hours or more often as needed. On August 11, 2025, at 4:32 PM, R1 was provided incontinence care by V8 (CNA) and V9 (CNA). R1 had a disposable brief with a thick pad inside the brief that was saturated through the thick pad to the brief. V8 stated the brief was very wet and was unsure when R1 had been previously changed. As of August 12, 2025, at 5:00 PM, V2 was unable to provide documentation of R1's incontinence care provided for the month of August 2025. R1's task documentation for the past 14 days in the EMR showed no data found. 2. R2's EMR showed R2 was admitted to the facility on [DATE], with multiple diagnoses including chronic respiratory failure with Hypercapnia, diabetes type 2, fusion of the spine, chronic pain syndrome, chronic pain syndrome, opioid dependence, anxiety disorder, and dependent personality disorder. R2's MDS dated [DATE], showed R2 was cognitively intact and required assistance with ADLs including set up assistance with eating, supervision with oral hygiene, rolling side to side in bed and upper body dressing, and substantial assistance with bathing, and personal hygiene and dependent on staff for toilet hygiene and putting on/taking off footwear and was always incontinent of bladder and bowel. On August 11, 2025, at 3:54 PM, R2 stated the previous day he had not been provided incontinence care from 3:00 PM until 10:08 PM. R2's room is under continuous video monitoring. V2 (Director of Nursing) and surveyor viewed the video surveillance for August 10, 2025, between 3:00 PM and 10:08 PM that R2 provided. The video showed staff did not provide incontinence care until 10:08 PM. As of August 12, 2025, at 5:00 PM, V2 was unable to provide documentation of R2's incontinence care provided for the month of August 2025. R2's task documentation for bladder incontinence for the past 14 days showed no data found. 3. R3's EMR showed R3 was admitted to the facility on [DATE], with multiple diagnoses including chronic obstructive pulmonary disease, congestive heart failure, type 2 diabetes, spinal stenosis of the lumbar area and anxiety disorder. R3's MDS dated [DATE], showed R3 was severely cognitively impaired and required assistance with ADLs including supervision with eating, oral hygiene, upper body dressing and rolling side to side, partial assistance with bathing, personal hygiene, and lower body dressing and dependent on staff for toileting, and was always incontinent of bowel and bladder. R3's care plan for incontinence, initiated on November 29, 2022, showed intervention to check R3 for incontinence every 2 hours and as needed. On August 12, 2025, at 1:33 PM, V14 (CNA) provided incontinence care to R3. V14 and R3 both stated R3 had last been changed around 10:30 AM that morning. V14 opened R3's brief, which was wet and visibly soiled with urine. As of August 12, 2025, at 5:00 PM, V2 was unable to provide documentation of R3's incontinence care provided for the month of August 2025. R3's task documentation for bladder incontinence for the past 14 days showed no data found. 4. R4's EMR showed R4 was admitted to the facility on [DATE], with multiple diagnoses including chronic obstructive pulmonary disease, hemiplegia and hemiparesis following cerebral infarction affecting the left non dominant side, morbid obesity due to excess calories, and anxiety disorder unspecified. R4's MDS dated [DATE], showed R4 was severely cognitively impaired and required assistance with ADL care including set up assistance for eating, supervision for oral hygiene, partial assistance with personal hygiene, substantial assistance with upper body dressing, dependent on staff for toileting, bathing, lower body dressing, and bed mobility. On August 12, 2025, at 1:53 PM, R4 was provided incontinence care by V13 (CNA) and V14 (CNA). R4 requested verbally to be provided with 2 briefs because she stated she doesn't like to lay in wetness. V13 provided 2 briefs for R4 and explained that is R4's preference because she doesn't like to have her bed linens getting wet and having to be changed. As of August 12, 2025, at 5:00 PM, V2 was unable to provide documentation of R4's incontinence care provided for the month of August 2025. R4's task documentation for bladder incontinence for the past 14 days showed no data found. On August 12, 2025, at 11:48 AM, V12</p>		

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F 0689  Level of Harm - Actual harm  Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.  (continued on next page)

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F 0689  Level of Harm - Actual harm  Residents Affected - Few	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to provide a safe environment and implement care plan interventions to prevent a fall that resulted in injury. This applies to 1 of 3 residents (R12) reviewed for falls in the sample of 14. This failure resulted in R12, experienced a fall that resulted in a right hip fracture and required hospitalization. The findings include: R12's EMR (Electronic Medical Record) showed R12 was admitted to the facility on [DATE], with multiple diagnoses including dementia, unspecified combined chronic diastolic and systolic congestive heart failure, history of falling and chronic kidney disease. R12 was transferred to the hospital on August 12, 2025. R12's MDS (Minimum Data Set) dated July 14, 2025, showed R12 was severely cognitively impaired, and needed assistance with ADLs including supervision with eating, partial assistance with oral hygiene and upper body dressing, substantial assistance with lower body dressing, bathing, bed mobility and transfer and dependent on staff for toileting. R12's fall prevention care plan, intervention added on February 14, 2025, showed R12 was at risk for falls and staff to get resident up early in the morning when awake and keep by the nurse's station. R12's fall care plan had an additional intervention added on May 21, 2025, that showed when observed awake keep her engaged in the common area until ready to go back to bed. On August 14, 2025, at 4:48 PM, V2 (DON) stated the intervention in February 2025, was added to R12's fall care plan as a result of a fall with no injury. V2 explained R12 liked to be active and move around and when she is awake it is best to keep her in an area where staff can see her. V2 explained R12 had experienced a fall in May 2025 that had resulted in a fracture wrist and the intervention was added that when R12 was observed awake to keep R12 engaged in the common area until ready to go to bed. V2 stated the post fall assessment was not done due to V17 (RN) had not started it at the time of the fall. The incident report dated August 12, 2025, at 5:25 AM, showed R12 was lying on the floor next to her bed and complaining of right hip pain and R12 stated she had hit her head. The report showed V16 (CNA) summoned V17 (RN) to report that R12 was lying on the floor. On August 14, 2025, at 4:36 PM, V17 stated she was the nurse assigned to R12 during the 11:00 PM, August 11, 2025, through 7:00 AM on August 12, 2025, shift. V17 stated she was passing medications in the hallway around 5:25 AM, when V16 summoned her to R12's room because R12 was lying on the floor. V17 stated she assessed R12 and found she was complaining of right hip pain and R12 stated she had hit her head. V17 stated she called 911, the physician, and the family to notify them of the fall and R12's complaint of pain. V17 stated R12 went to the hospital via ambulance at 5:50 AM. V17 stated she saw a mat in use at the time of R12's fall. On August 15, 12:37 PM, V16 was interviewed by phone. V16 stated on August 11, 2025, at 11:15 PM on her first rounds, she found R12 sitting on a thick mat that was sitting next to the bed, the height of the mat was almost equal to the height of the bed. V16 stated she assisted R12 who was awake and alert, back into bed. V16 stated she then took the thick mat and propped it up, adjacent to the right side of the bed and the left side of the bed was against the heating unit which was attached to the wall with the window. V16 stated she had boxed R12 into the bed so she wouldn't get up and fall. V16 stated the next time she observed R12 was around 2:15-2:20 AM, and R12 was awake but was not moving around and the mat was still in place propped up against the right side of the bed. V16 stated she started her next rounds around 4:20 AM but started the rounds on the opposite end of the hall from where R12's room was. V16 stated she reached R12's room around 5:25 AM, on August 12, 2025, and found R12 lying on the floor on her right side in a fetal position with her head at the foot of the bed. V16 stated the propped-up mat was still in place and stated R12 must have crawled or scooted out of the end of the bed over the footboard and then fell on the floor. V16 stated she works on all the units in the facility. V16 stated she was not sure of what R12's care plan interventions to prevent falls were. V16 stated no facility staff had interviewed her as of yet as to how R12 had fallen. On August 15, 2025, at 4:12 PM, V2 stated she had not spoken to V16 regarding the cause of R12's fall and V2 stated she was unsure if the restorative nurse had spoken to V16. R12's Xray report from the hospital dated August 12, 2025, showed R12 sustained a mildly comminuted displaced right femoral intertrochanteric fracture, a right hip fracture. V11 (R12's Physician) stated on August 15, 2025, at 3:53 PM, that R12 having barriers on both sides of the bed would be an unsafe situation, especially due to R12 being cognitively impaired. V11 stated the likely cause of R12's hip fracture was the fall that occurred on August 12, 2025. The facility's policy titled Evaluating Falls and Their Causes, dated August 2008, showed, General Guidelines .5. Residents must be evaluated for potential causes of falls immediately. 6 Environmental issues must also be</p>		