

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  03/27/2026
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 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review the facility failed to have orders in place to manage a resident's PICC (peripherally inserted central catheter) Line. This applies to 1 of 3 residents (R1) reviewed for intravenous lines in the sample of 3. The findings include: R1's Face Sheet shows that he was admitted to the facility on [DATE] with diagnoses including Nontraumatic Subarachnoid Hemorrhage, Acute and Subacute Infective Endocarditis, Pleural Effusion and Psychoactive Substance-induced Mood Disorder. R1's admission orders include the administration of 2 IV (intravenous) antibiotics to be administered through the PICC Line 2-3 times a day. R1's admission orders show no orders for the care, flushing or dressing changes for the PICC Line. On 3/27/26 at 12:35PM V4(RN-Registered Nurse) stated, We do routine flushes, dressing changes every 7 days, check to make sure there is a cap on the end, when we remove it, we measure it, check arm circumference. The night shift does all of that. Those orders are part of the batch orders that are put in on admission. On 3/27/26 at 1:05PM V2 (Director of Nursing) stated, Usually we change the dressing once a week on Sundays on PICC lines and midlines. It is part of our batch orders. Orders were not put in for R1.</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
---	-------	-----------

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  03/27/2026
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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review the facility failed to administer antibiotics as ordered by the physician and notify the physician when those antibiotics were not administered. This applies to 1 of 3 residents (R1) reviewed for significant medication errors in the sample of 3. The findings include: R1's Face Sheet shows that he was admitted to the facility on [DATE] with diagnoses including Nontraumatic Subarachnoid Hemorrhage, Acute and Subacute Infective Endocarditis, Pleural Effusion, and Psychoactive Substance-induced Mood Disorder. R1's Medication Administration Record (MAR) dated February 2026 shows that R1 was scheduled to receive Vancomycin (Antibiotic) 1750mg/350ml every 12 hours for infection. This same document shows that R1's dose of Vancomycin was not administered on 2/26 at 9:00PM, 2/27 at 9:00PM, 2/28 at 9:00AM and 2/28 at 9:00PM. On 3/27/26 at 11:00AM V3 (LPN- Licensed Practical Nurse) stated, I don't know why I did not give the Vancomycin on those days. He came in on the 26th- it probably wasn't available. On the 27th he went to the hospital because he called 911 on himself and I don't know about the 28th. I think it was on hold that day. He has to have a blood test then the results are sent to the pharmacy then they send out the Vanco to us. Usually comes between 11PM and 1AM. On the 27th he called the ambulance on himself. He came out of his room and ran down the hall. The ambulance was already here. He said the PICC Line was out, but the PICC line was not out. He had said the medication was all over the floor, but me and a CNA went in there and there was nothing on the floor. The hospital said his PICC line was fine. He did not come back on my shift. R1's Vancomycin Trough drawn on 2/28/26 result shows it was an Alert Low of 3.6 (Normal 10-20). This lab was drawn at 10:10AM, Received at the lab at 1:25PM and reported to the staff at the facility at 2:52PM. On 3/27/26 V2 confirmed that from there the facility would notify the pharmacy. The next Progress Note in the R1's EMR (Electronic Medical Record) is from 3/1/26 at 3:19PM and states, Call from (Pharmacy) at 10:50AM with instructions to continue same dose of Vancomycin and check BMP (Basic Metabolic Panel) and Vanco Trough on 3/3/26. V2 also confirmed that R1's Vancomycin was administered on 3/1/26 at approximately 9:30AM prior to hearing from the pharmacy regarding the lab results/dose recommendation from 2/28/26. The Pharmacy Packing Slips dated 2/27/26 at 4:19 AM, 2/27/26 at 10:50AM and 3/1/26 at 5:34AM shows that there was a total of 8 doses of Vancomycin delivered to the facility during R1's stay from 2/26/28-3/3/26. R1's February and March 2026 MARs show that he only received 5 of those doses of Vancomycin. R1's Progress Notes dated 2/27- 3/1 do not document any notification to R1's physician regarding the missed doses of Vancomycin.</p>		