STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145420	A. Building B. Wing	04/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgeway Senior Living	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)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the safety of resident during care. This failure resulted in R1 falling from her bed during peri care, sustaining a scalp laceration, and needing transferred to a local hospital for sutures. This applies to one of three residents (R1) reviewed for safety in the sample of three. This past non-compliance occurred from 3/29/26 to 3/30/26.The findings include:The facility face sheet for R1 shows she was admitted to the facility with diagnoses to include conversion disorder with seizures, dementia, aphasia (communication disorder) and dysphagia (difficulty swallowing). The facility assessment dated [DATE] shows R1 to have severe cognitive impairment and is dependent on staff for all care including bed mobility.The Facility Fall Report dated 3/29/26 shows that at 2:20 PM that day, R1 was being assisted with incontinence care by V3 Registered Nurse (RN) while R1 was lying in bed. R1 was lying on her right side when V3 was reaching over to grab a towel, R1 rolled out of the bed onto the floor. The report shows R1 was bleeding from a cut to her head and was sent to the local emergency room and received sutures.On 4/25/26 at 9:49AM, V3 said R1's daughter came to her on the afternoon of 3/29/26 stating her mother had been incontinent and needed to be cleaned up. V3 said R1 is nonverbal and is completely dependent on staff to care for her and turn her. V3 said she gathered the supplies she needed and proceeded to R1's room. V3 said the daughter left the room as she was providing care alone to R1. V3 said she was nearly done, and had R1 on her right side, and V3 said she reached to the left for a towel. V3 said she had a hand on R1 the whole time. V3 said at that moment, the bed alarm went off and R1 rolled out of the bed and fell to the floor. V3 said she observed blood coming from where a small cut was observed to the back of R1's head. V3 said she immediately assessed the resident, called the Physician, and sent R1 to the emergency room. V3 said she should have had another staff member present to assist with the care for R1.On 4/25/26 at 10:50 AM, V4 Certified Nursing Assistant (CNA) said R1 is totally dependent on the staff to move in her bed. R1 cannot assist with her care at all. V4 said R1 is always to be a two assist with her care.On 4/25/26 at 10:53 AM, V2 Director of Nursing (DON) said she investigated the fall for R1, and it seemed she just rolled off the bed during incontinent care. V2 said it was an unfortunate accident. V2 said R1 required the assistance of two staff for her care. V2 said after the fall, two bolster pillows were added to each side of R1's bed to prevent her from rolling out, all nursing staff were educated on having two staff present during all care with dependent residents. V2 said competency screening was completed for V3 and audits on staff completing care for dependent residents using two staff. V2 said this was all completed the next day on 3/30/26.The care plan for R1 for Activities of Daily Living shows an undated intervention for bed mobility, resident is totally dependent to roll left and right with two staff.The emergency room report dated. 3/29/26 shows R1 was seen after being rolled out of her bed onto the floor during care when the staff stepped away. A laceration measuring one centimeter was observed to the back of R1's head which required two staples.Prior to the survey of 4/25/26, the facility had taken the following action to correct the noncompliance:1. On 3/29/26, the facility added bolster pillows to R1's bed and in serviced staff on ensuring that there should be two staff present when performing perineal (continued on next page)

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 0689 Level of Harm - Actual harm Residents Affected - Few	care for a dependent bed bound resident.2. On 3/30/26, all facility nursing staff were re-educated/in-serviced on ensuring that there should be two staff present when performing perineal care for a dependent bed bound resident.3. On 3/30/26, competency on transfers and repositioning was done for both nurses and CNAs.4. On 3/30/26, audits for ADL (Activities of Daily Living) provided for dependent residents using two staff was started.5. On 3/30/26, a QAA discussion was completed, and the facility implemented a performance Improvement Plan (PIP).