STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0053363	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWAY SENIOR LIVING	**111 EAST WASHINGTON , BENSENVILLE, Illinois, 60106**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	Initial Comments Investigation of Complaints: 2577508/2585318 2577642/2588499 2577102/2579033	S0000		08/16/2025
S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS: 300.610a) 300.1210b) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's	S9999		08/16/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d)Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. THESE REQUIREMENTS WERE NOT MET EVIDENCED BY: 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. R12's EMR (Electronic Medical Record) showed R12 was admitted to the facility on December 23, 2024, 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.	S9999		

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S9999	Continued from page 2 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 7:00AM 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	S9999		

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S9999	Continued from page 3 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 addressed immediately…. Steps in the Procedure…3. Identifying Causes of a fall or fall Risk a. Within 24 hours of fall, the nursing staff will begin to try to identify possible or likely causes of the incident…b. Staff will evaluate the chain of events or circumstances proceeding a recent fall including…3. The activity the resident was engaged in… 6. whether the resident was responding to an urge to void. 7. Whether there were environmental factors involved (e.g. slippery floor, poor lighting, furniture, or objects in the way…c. The staff will continue to collect and evaluate information until they either identify a cause of falling or determine the cause cannot be found ". (A)	S9999		