STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510077	A. BUILDING: _____ B. WING _____	C 02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF WHEATON	831 E BUTTERFIELD RD WHEATON, IL 60189

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A 000	Initial Comment FRI (Facility Reported Incident): #IL183215 - Substantiated. However, there was no establishment failure. No deficiencies written. FRI (Facility Reported Incident): #IL184146 - Not Substantiated. However, allegation was not reported to the Department in a timely manner. 295.6010 was cited. FRI (Facility Reported Incident): #IL186085 - Not substantiated. No deficiencies written.	A 000		
A6010	Section 295.6010 Abuse, Neglect, and Financial Exploitation Pr This Regulation is not met as evidenced by: Type 3 Violation Section 295.6010 Abuse, Neglect, and Financial Exploitation Prevention and Reporting a) When the establishment has a reasonable belief that a resident has been the victim of abuse, neglect, or financial exploitation, the establishment shall: 1) Notify the Department within 24 hours after receiving such allegation, by contacting the Assisted Living Complaint Registry by telephone, fax, or other electronic means. The establishment shall document this report and maintain documentation on the premises for 12 months after the date of the report. 2) Investigate and develop a written report	A6010		

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A6010	Continued From page 1	A6010		

within 14 days after the initial report. The establishment shall send the written report to the Department within 24 hours after it is completed and shall maintain a copy of the written report on the premises for 12 months after the date of the report.

b) A written report of the investigation conducted pursuant to subsection (a)(2) shall contain at least the following:

1) Dates, times, and description of the alleged abuse, neglect, or financial exploitation.

2) Description of any injury to the resident.

3) Description of any change in the resident's physical, cognitive, functional, or emotional condition.

4) Any actions taken by the licensee.

5) A list of individuals and agencies interviewed or notified by the establishment.

6) Names of witnesses to the alleged abuse, neglect, or financial exploitation; and

7) If the abuse, neglect, or financial exploitation is substantiated, a description of the action to be taken by the establishment to prevent the abuse, neglect, or financial exploitation from occurring in the future.

c) Establishment employees and volunteers are obligated to report abuse, neglect, or financial exploitation of a resident to the establishment management and to the Department.

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A6010	Continued From page 2 d) When the establishment has a reasonable belief that abuse, neglect or financial exploitation occurred, the perpetrator, if an employee or volunteer, shall be removed from direct contact with residents. These requirements are not met as evidenced by: Based on interview and record review, the establishment failed to report to the Department an allegation of verbal abuse from an employee towards a resident within the required time frame from receiving the allegation. They also failed to send the final written report within 14 days after the initial report. The establishment also failed to follow their Abuse Policy regarding physician and POA notification regarding the abuse allegation incident and failed to follow their performance improvement plan for the employee involved in the alleged abuse. This applies to 1 (R1) resident reviewed for abuse investigation. Findings include: R1 is an 89-year-old male resident admitted to the establishment on June 21, 2024 with diagnoses of right femur fracture, HTN, atrial fibrillation, anemia, dementia, anxiety, heart disease without heart failure, pain in right leg, unsteadiness on feet, abnormality of gait and mobility, history of falling, cognitive communication deficit, and dysphagia, oropharyngeal phase. E1 (Executive Director) said she was not an employee of the establishment when the verbal	A6010		

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A6010	Continued From page 3	A6010		

abuse allegation happened, but she could get all the information regarding this investigation.

E1 presented information regarding the establishment's internal investigation and the conclusion of their investigation related to this incident, records/documents for R1, and records/documents of the employee involved in the allegation.

The establishment's Incident and Accident Report showed on December 28, 2024, an employee (E3-Care Manager) reported he saw another employee (E4-Care Manager)) grabbed a resident by the shirt and yelled "shut up" directed at the resident.

An internal investigation was conducted. Interviews of the employees who worked during the shift, and the resident were also done. The internal investigation yielded unsubstantiated result due to the resident's cognitive deficit which made him unable to recall the events of the alleged incident. The internal investigation also showed E3 (CM) claimed he witnessed E4 (CM) told R1 to "shut up" or grabbed R1's shirt. E4 denied he told R1 to "shut up" or grabbed R1's shirt. The resident was unable to substantiate the claims made by E3.

E4 was suspended when the allegation was lodged pending investigation. After the unsubstantiated result of the investigation, he was reinstated and was relocated from the Memory Care wing of the establishment to the Assisted Living wing where he was to receive additional supervision and assists residents who do not have cognitive impairment.

E4's Performance Counseling and Improvement

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A6010	Continued From page 4 Plan (For Corrective Action) after the incident on February 8, 2024 showed the action plan for the performance improvement plan as: additional training will be provided on appropriate responses to residents and to resident behavioral expressions. There was no record/documentation that E4 was given any in-service/re-education regarding Abuse and additional training regarding appropriate responses to residents and to resident's behavioral expressions as written in the plan of improvement. The establishment's Abuse, Neglect and Exploitation - Prevention, Reporting and Investigation Policy revised August 2024 showed: Ensure that the physician's physician, legal representative, and family member or other individual regularly involved in the resident's day-to-day care are notified as soon as practicable within timeframes established within laws/regulations. There were no documentation R1's POA and physician were notified regarding the incident as outlined in the establishment's Abuse, Neglect and Exploitation - Prevention, Reporting and Investigation Policy. The allegation that happened on December 28, 2024 was not initially reported until December 30, 2024 (48 hours after the incident). The follow-up/final report was not sent to the Department until January 29, 2025 (more than a month after the incident). The establishment conducted in-service/re-education to their employees regarding Abuse and Neglect on January 25, 2025 (almost a month after the incident).	A6010		

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A6010	Continued From page 5 E2 (REM/MC Coordinator) said the allegation happened on a weekend so they did not report it until Monday. The final report was sent by the Division Senior Executive Director, who was interim ED at that time. E1 (Executive Director) and E2 (REM/MC Coordinator) said they will make sure E4 will receive his additional training and in-services as outlined in his performance improvement plan.	A6010		