STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510076	A. BUILDING: _____ B. WING _____	C 12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF ST CHARLES	600 DUNHAM RD SAINT CHARLES, IL 60174

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A 000	Initial Comment Facility Reported Incident IL198936 295.6000a) 5) 13) Complaint Investigation Survey 25712047/IL198958. No deficiency cited.	A 000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Type 1 Violation Section 295.200 Definitions Neglect - a failure by the establishment to provide services, as outlined in the service delivery contract; a failure to notify the appropriate health care professional that an assessment is necessary in accordance with the service plan; a failure to modify a service plan, as appropriate, based on a new physician's assessment; or a failure to terminate the residency of an individual whose needs can no longer be met by the establishment, which failure results in an avoidable decline in function. Section 295.6000 Resident Rights a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights: 5) The right to receive the services specified	A6000		

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A6000	Continued From page 1 in the service plan, to review and renegotiate the service plan at any time; and to be informed of the cost of the changes. 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor. These requirements are not met as evidenced by: Based on interview and record review, the establishment failed to follow an intervention in the resident's Service Plan regarding respiratory assessment for a resident with diagnosis of chronic obstructive pulmonary disease, and consequently failed to report to the resident's physician the result of the assessment. They also failed to respond, in a timely manner, a call for assistance from the same resident via his call pendant. These failures contributed to a resident being found unresponsive in his room and consequent death. These failures creates a substantial probability to cause severe harm or death to other residents. This applies to 1 (R1) resident reviewed for a facility reported incident of death in the establishment. The findings include: R1 is a 76-year-old male resident admitted to the establishment on October 3, 2024, with diagnoses to include chronic obstructive pulmonary disease, unspecified asthma, gastritis, cerebral infarction, and atrial fibrillation.	A6000		

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A6000	Continued From page 2 E3 (LPN) and E2 (Resident Care Director-RCD) confirmed R1 expired in the establishment on November 20, 2025. R1's Service Plan with initiated date of October 4, 2024 showed R1 had a physician order for a requested Full Code status. The establishment's Incident and Accident Report/Incident Notification, and Progress Notes were reviewed. The same documents dated November 20, 2025, showed the night shift nurse on duty responded to a call from caregiver. The nurse on duty was called to R1's apartment due to concerns of low oxygen reading. Resident had a personal pulse oximeter that he used throughout the day. Nurse assessed oxygen saturation with reading fluctuating between 8-92%. The nurse checked R1's Oxygen concentrator and found oxygen tubing to have water inside. Nurse changed oxygen tubing and reassessed oxygen saturation level to be improved at 93%. The nurse returned to the resident's room at 3 AM and assessed oxygen saturation level to be between 90-93%. No discoloration of lips or extremities. The resident had no complaints and remained sitting in his chair. The nurse on duty returned to the resident's apartment at 5:15 AM, and observed resident to be sitting in his chair, verbally responded "I am ok" when asked how he was feeling. Oxygen saturation was at 88%. Physician ordered oxygen parameters between 88-94%. At 7:08 AM, the morning shift nurse on duty was called to resident's apartment. Care managers stated resident was unresponsive. The resident	A6000		

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A6000	Continued From page 3	A6000		

was received in his reclining chair, leaning to his side and pale in color. Nurse on duty took vitals and reviewed code status (full code) CPR initiated and 911 called. EMTs arrived at 7:10 AM. Family, MD, Resident Care Director, and Executive Director were made aware. EMTs not able to resuscitate resident. Time of death declared by EMT.

Investigation was initiated and involved team members were interviewed.

Review of the written Statement of Events from Staff members showed: LPN for incoming morning shift was notified by the care managers the resident in room 327 was unresponsive. LPN called 911. CPR was initiated with guidance from 911 personnel until EMTs took over.

The Statement of Events from E16 (Night Supervisor) showed on 11/20/2025, E16 answered calls from R1 approximately between 12 AM to 1 AM during nightshift related to having low oxygen while checking with pulse oximeter at 88%. E16 educated R1 regarding oxygen baseline to be at 88-92%. Oxygen concentrator checked and was working properly to tubing and nasal cannula changed. Assisted with putting on cannula. O2 saturations at 93%. R1 called again with some concerns at 3 AM. Reassured oxygen working properly. Pulse oximeter reading between 90 to 93 %. Writer stayed in suite until resident remained calm...R1 sat on recliner chair, pendant left in place. Reminded on use of pendant or call with any other concerns. At 5:15 AM, resident sitting on recliner replied, "I am ok." While nodding head. O2 at 89%.

R1's Service Plan Report with creation date of May 25, 2025, and revision date of September

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13, 2025, showed a Focus on Respiratory System. The Goal was to be free of any signs and symptoms of respiratory distress. One of the Interventions under this category was to observe for and report for any of the following signs or symptoms of respiratory distress: increased respirations, increased heart rate, restlessness...

The same Service Plan showed under the category of Sleep Pattern: Resident has no difficulty sleeping.

There was no documentation that a thorough assessment of the resident's other vital signs, respiratory condition, respirations, and heart rate was conducted. The night shift nurse on duty/night supervisor did not document R1's lungs were auscultated so the result could be properly reported to the physician for further interventions.

R1 was up in his chair, did not sleep, called for assistance from 12 AM and in between hours throughout the shift, showed anxiety which was unusual for him as he was assessed in his Service Plan as having no difficulty sleeping. He was in obvious distress. This, along with other respiratory symptoms and assessment were not reported to the physician for more interventions.

Another written Statement of Events from E4 (AM shift Lead Care Manager) showed on November 20, 2025, at 6:22 AM, E4 met E15 (Night Shift Care Manager) at the elevator. E4 told E15 she was going to give a shower to one of her residents on the second floor. E4 put her things away and grab her scout phone and walkie. E4 checked her scout phone and saw two people calling. E4 assumed E15 would answer and clear the pendants since she stated she was starting a shower right away. After E4 finished the shower,

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A6000	Continued From page 5	A6000		

she went to get rid of the soiled linens and observed E15 in the laundry room. E4 asked E15 why she did not reset the two calls since E15 knew she was doing the shower. E15 stated, "My phone died." E4 asked E15 why she did not grab a new scout phone, since there were four already charging. E15 stated, "I don't have time to get a new phone."

The written Statement of Events from E15 (Night Shift Care Manager) showed E15 was called twice during the shift by R1. E15 also called the nurse both times. R1 asked E15 during the 2nd call to give him his portable oxygen machine. E15 checked him at 3:30 AM. R1 was in his chair sleeping. The nurse also told E15 she checked on him when she was passing her AM medications, which she did at around 5 AM. E15 wrote her last call was for 205. E15 told resident she would be getting her up around 6:30 AM. In between that 5:00 AM call, E15's phone died, but she did not know. She went on to take the laundry to the resident's room. At 5:30, E15 was in room 329 getting resident cleaned up to dress for the morning. E15 went to room 336 to assist her in getting dressed. E15 wrote she answered all the calls. The nurse did not have the phone like the care manager, So E15 wrote she's the only one responding to the calls and getting resident up, dressed, and ready by 7 AM.

The establishment's Device Activity Report from November 19, 2025-November 20, 2025, showed on November 20, 2025, R1 pressed his call alarm at 6:03 AM, but the call was not answered until 7:08 AM.

A Narrative from the local Police Department investigation dated November 20, 2025 showed E1 (Senior General Manager-Sr. GM) was

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A6000	Continued From page 6 interviewed and communicated a common response to pendant request is 4-5 minutes. E1 added there was a miscommunication between staff members over who was responding to the call as they were both attending to other residents. E1 (Sr. GM) and E2 (RCD) confirmed there was no other documentation they could provide to show the nurse on duty conducted other assessments, auscultation of the resident's respiratory status/lung condition so the findings could be properly reported to the physician for further interventions. They also said they made changes to the response method by their staff regarding call alert. The nurse should be included in the call alert from residents so everybody would be able to respond in a timely manner. The call alert should not be going to the care managers only. E1 and E2 added they now put a system in place and already conducted in-services for their staff members using their new system to respond to call alerts from residents.	A6000		