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 12/08/2024

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

(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) COMPLETE DATE
A 000	Initial Comment Original investigation of FRI IL 181930. 295.6000 a) 13) cited.	A 000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: 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: 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; GENERAL VIOLATION Based on record review and interviews, the establishment failed to prevent verbal abuse of one of one sampled residents. (R1) Findings include: On 12/8/24 at 10:30 A.M., R1 stated that on 11/15/24 at around 3:30 A.M. R1 had pressed her call light for assistance. R1 stated that she had a coughing spell which caused her to urinate in her incontinent brief. R1 said that E3 (Caregiver) came into her room and said very loud and rudely, "What do you want? Your'e calling to soon. I'm in the middle of helping someone else." R1 said that E3 left her room at that point. R1	A6000		

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A6000	Continued From page 1	A6000		

said that she then pressed her call light again a few minutes later to ask for the nurse, since she was still wet with urine. R1 said that E3 again came in and before R1 could say anything, E3 yelled, "I'm not your slave and I'm not your girl." R1 said this felt very aggressive and scared her. R1 said that she told E3 to please leave and get the nurse for her. R1 said that E3 then left but came back in just a few minutes later yelling at her, saying how disrespectful R1 was being to E3. R1 again asked E3 to leave. R1 said that E4 (Nurse) then came in just a little bit later and R1 told her how E3 had treated R1. R1 said that she was not able to go back to sleep the rest of the night because she was so upset.

Facility "Incident Summary" reads, "On November 15, 2024, resident (R1) reported an incident involving a care manager (E3) who responded to her call light at approximately 3:30 A.M. The resident (R1) alleged that the care manager (E3) was argumentative and stated that she would not assist (R1) at that time as other residents were prioritized. Furthermore, (E3) allegedly made an inappropriate and unprofessional remark, 'I am not your slave, and next time I won't come in when you call.' The resident (R1) emphasized that (E3) was not physically abusive. (R1) is alert, oriented x3 and considered a credible source."

Facility "Investigation Summary" reads, "Upon receiving the report, the care manager (E3) in question was immediately placed on administrative leave pending an investigation. The investigation included interviews with the resident (R!), the care manager (E3), and other staff on duty during the incident. The resident's (R1) account was consistent and credible. The investigation concluded that the care manager's (E3) conduct was in violation of professional and

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A6000	Continued From page 2 ethical standards of care. Outcome: Based on the findings, the care manager (E3) employment was terminated effective immediately following the completion of the investigation." On 12/8/24 at 9:55 A.M. E2 (Resident Care Director R.N.) confirmed that through their internal investigation they did confirm that E3 did verbally abuse R1 on the night of 11/15/24 and that E3's employment was terminated as a result. Facility's "Performance Counseling and Improvement Plan" dated 11/22/24 reads, "(E3) was verbally abusive to resident (R!) on 11/15/24 when she went in to provide assistance to the resident after the resident called for assistance, causing emotional distress to the resident. This behavior is not acceptable at (Facility) or any senior living facility, and as a result of the severity of the infraction, (E3's) employment has been terminated."	A6000		