

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145621	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/28/2025
NAME OF PROVIDER OR SUPPLIER  Pavilion of Waukegan		STREET ADDRESS, CITY, STATE, ZIP CODE 2217 Washington Street Waukegan, IL 60085	

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)
<p>F 0675</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor each resident's preferences, choices, values and beliefs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review the facility failed to provide R1 with the necessary care and services to maintain the highest practicable physical and psychosocial well-being for 1 of 6 residents (R1) reviewed for quality of care in the sample of 6. The findings include: On 10/27/25 at 10:35AM, R1 was lying in bed watching television. R1 sat up on the side of the bed and placed her feet on the floor. R1 said, a couple of weeks ago one of the CNAs (Certified Nursing Assistant) took my vital signs and said, I am going to help you with your shower. I told the CNA I can do it myself. I have been here 5 years and only needed someone to help me with my back. The CNA's hands were all over me. I told the CNA to stop. The CNA said, take it easy. In the past, the staff would provide privacy while I washed myself. The staff may have washed my back, now I have a back brush; no one is touching me again. When the CNA started washing me. I told the CNA to stop. The CNA thought I was being funny. I said, you are a sex maniac. You do not belong in the health field. I got myself dressed. I have not seen the CNA after that. When I do it myself, I do not have to rush. I do not have to worry about being looked at. I feel I do a better job. I feel so good, so clean, I am happy. On 10/27/25 at 12:16PM, V10 (CNA) said, R1 can wash independently. R1 will often give herself a sponge bath instead of taking a shower. There have been times where I will go to get R1 ready for the shower and R1 has already completed the bath. R1 does not like to be touched by anyone, ever. R1 refuses the skin check, always. On 10/27/25 at 2:35PM, V9 (CNA) said, staff will always be in the shower room with every resident. We allow the resident to be as independent as their ability allow. We want to maintain the resident's functional ability. On 10/28/25 at 10:15AM, V5 (CNA) said, I do not usually work on R1's unit. I'm the first CNA that showered R1. One of the nurses told me I cannot force the resident to take a shower. I explained to the nurse that I re-direct the residents. I re-directed R1. I explained the rationale and R1 agreed. R1 is alert. R1 knows what is going on. If R1 did not want the shower, R1 would be resistive. R1's Minimum Data Set, dated [DATE] shows, Brief Interview for Mental Status 15/15 Mentally Intact. No upper or lower extremity impairment. Shower: Supervision with touch assist. R1's Care Plan on 10/11/25 shows, Focus: The resident has an ADL self-care performance deficit. Date Initiated: 03/22/2019. Goal: The resident will maintain current level of function through the review date. Interventions: Encourage the resident to use bell to call for assistance. Praise all efforts at self-care. R1's Bathing/Shower preferences was not initiated in the Care Plan until 10/13/2025. R1's Abuse Investigation date 10/13/2025 shows, on 10/11/2025 V5 (CNA) made (R1) feel uncomfortable when the CNA offered to help. The CNA was not aware of R1's showering preferences.</p>

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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