

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 12/02/2025
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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to implement safety interventions for 2 of 2 residents (R1, R2) reviewed for safety in the sample of 3. This failure resulted in R1 being hit in the face by R2's involuntary movements. The findings include: R1's face sheet printed on 12/2/25 showed diagnoses including but not limited to Alzheimer's disease, non-traumatic brain dysfunction, and mood disorder. R1's facility assessment dated [DATE] showed R1 has severe cognitive impairment and uses a wheelchair. R1's progress note dated 11/25/25 stated: At around 6:30 pm resident was sitting near the first-floor nurses' station next to a male resident who struck her on the right side of her face. Writer immediately separated the residents and assessed resident's eye and face, there appeared to be no injury, 911 called., Progress notes showed R1 was transported to the local emergency room and returned the same day without injury. R2's face sheet printed on 12/2/25 showed diagnoses including but not limited to Parkinson's disease, dementia, anxiety, legal blindness, and extrapyramidal movement disorder (neurological/range of movement disorder caused primarily by medication side effects). R2's facility assessment dated [DATE] showed R2 has moderate cognitive impairment and uses a wheelchair. R2's progress note dated 11/25/25 stated: At around 6:30 pm resident was sitting next to a female resident near the first-floor nurses' station when he struck the female resident on the right side of her face, writer immediately separated the residents, called 911 for the female resident. Progress notes showed R2 was transported to the local emergency room and returned the same day without injury. On 12/2/25 at 11:14 AM, R1 was attempted to be interviewed. R1 was pleasantly confused and had no memory recall. R1 did not show any signs of injury or pain. On 12/2/25 at 12:55 PM, R2 was attempted to be interviewed. R2 was unable to provide any details regarding the 11/25/25 event. R2's head, hands, and mouth moved uncontrollably during the interview. On 12/2/25 at 10:23 AM, V2 (Licensed Practical Nurse/LPN) stated R1 and R2 both went out the local hospital last week for medical evaluations. R2 has uncontrollable arm movements, and his hands were swinging around and hit R1. V2 said she did not witness it but heard about it during the morning report. V2 said R1 is confused and does not remember anything about it. R1 was not injured during the interaction. On 12/2/25 at 10:50 AM, V1 (Director of Nurses) stated R2 has a history of spastic body movements due to his diagnosis of extrapyramidal movement. He had an involuntary arm movement, and his hand brushed across R1's body. V1 said R2 was seated too close to R1 and his hand hit her face. V1 said the nurse on duty (V3) was present and witnessed the event. On 12/2/25 at 12:07 PM, V3 (LPN) stated he was seated at the nurses' station on 11/25/25 at around 6:30 PM. V3 said he looked up and saw R2's open hand come in contact with R1's face. V3 said it looked unintentional. V3 said he immediately intervened and separated both residents. V3 said R2's body was jumping up and down in his wheelchair. V3 said he has seen R2's body moving the same way in the past. R2's swings his arms around and can't stop the movement. R2 has had the movements since he was admitted (6/2024). V3 said staff try to keep R2 spaced away from other residents. V3 said an aide likely moved R2 too close to R1. It happened so fast there was no time to separate him. Plus, R2 is a tall man with long arms. They really didn't seem all that close, until after it happened. V3 said both residents were sent to the local emergency room. Both residents returned the same day with no injuries or new orders. On 12/2/25 at 12:24 PM, V4 (Certified Nursing Assistant/CNA) stated she was working the PM shift on 11/25/25. V4 said she did not see the event with R1 and R2 but heard V3 yelling Stop it. V4 said she ran down to the nurses' station and V3 had already separated R1 and R2. Both residents were seated in wheelchairs and looked like their normal, confused selves. V4 said R2 has lots of arm movements and has accidentally swung at another resident in the past. R2 has had the uncontrollable arm movements since she has worked there. R2 has a problem controlling his head and hands too. V4 said staff keep him away from other residents and put him in areas where he can't accidentally hit things. R2 sits in the dining room at a table by himself. V4 said the aides push residents in wheelchairs out of the dining room and place them by the nurses' station. Someone must have moved them out and they ended up next to each other. V4 said obviously no one was thinking about keeping R2 away from others that day. On 12/2/25 at 1:37 PM, V6 (CNA) stated R2 tends to have uncontrollable body movements. He is not always aware of his surroundings and his arms move by themselves. Some days the body movements are worse than other, but it goes on throughout the day. R2 will touch his face repeatedly and move his head around. V6 said we try to keep him away from other residents. We sit him alone, so his arms are not swinging out at others. R2's care plan showed a focus area</p>		