STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145621	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waukegan Health and Rehab	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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to protect the resident's right to be free from physical abuse by another resident for 1 of 2 residents (R1) reviewed for abuse in the sample of 7. The findings include:R1's face sheet showed he was admitted to the facility 3/17/26 with diagnoses to include senile degeneration of brain, cellulitis of left upper limb, dementia, muscle weakness, and atrial fibrillation. R1's facility assessment dated [DATE] showed he has severe cognitive impairment and requires substantial to maximum assist of staff for most cares. R1's Care Plan initiated 3/20/26 showed, The resident's memory is impaired. Consequently, the resident has problems with decision-making, insight, logic, calculation, reasoning, planning, and judgement. R1's Care Plan initiated 4/2/26 showed, the resident has a history of behavior problem such as hitting staff related disease process. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed.R1's 4/19/26 Nurses Note showed, The CNA (Certified Nursing Assistant) who just came back from her break reported to this writer that she saw the two residents by the hallway just outside their bedroom. According to the CNA, [R1] was hit by his roommate on the left side of the face and top of the head, the third punch was blocked by the resident. Both were in their wheelchairs. The two residents were separated immediately, [R1] was removed right away farther from his roommate. Skin assessment conducted immediately and noted redness to the left side of [R1's] face as well as the back of the right hand on the lateral side.R2's face sheet showed he was admitted to the facility 10/4/24 with diagnoses to include chronic congestive heart failure, urinary tract infection, dysphagia, dementia, major depressive disorder, and low back pain. R2's facility assessment dated [DATE] showed he has no cognitive impairment and requires substantial to maximum assist with most cares.R2's Care Plan initiated 1/30/26 showed, The resident demonstrates a potential for situational and/or coping problems in areas such as: Psychosocial well-being mood state and/or behavioral symptoms. Behavior may leave resident susceptible to abuse: This appears related to: . Dementia, depression with psychotic features. Symptoms are or may be manifested by: Cognitive deficits (poor reasoning, poor memory, poor judgement) . Conflictual relationships with staff and peers. Intervene on an incidental or episodic basis to re-direct behavior symptoms that impact others. (4/20/26) Set limits to behaviors. Stay calm when resident is exhibiting agitated behaviors. If behavior is disruptive and if showing aggression towards other residents-separate from other residents.R2's 4/22/26 Physician Progress Note showed, . RN (Registered Nurse) reports that patient has been refusing medications more frequently, recently had an altercation with another resident.The facility's Incident dated 4/19/26 at 7:05 PM showed, Resident to Resident. The two residents were separated immediately, [R1] was removed right away farther from his roommate. Skin assessment conducted immediately and noted redness on the left side of [R1's] face as well as the back of the right hand on the lateral side.The facility's Incident dated 4/19/26 showed, . Patient was sitting in the doorway of his room when resident [R1] was attempting to gain access to his room, resident [R2] swung and struck resident [R1] in the face.On 4/29/26 at 11:36 AM, V8 (Registered Nurse/RN) said, (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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The only injury from the incident was [R1] had some redness on his cheek, and he had some redness on his hand. From what I was told, it was just [R2] that was swinging.On 4/29/26 at 12:17 PM, V7 (CNA) said, I am familiar with the issue. I wasn't the one that witnessed it, but I did hear about it. I was on break and when I got back, [V12 Agency CNA] told me about the situation. I did notice redness on [R1's] face. The redness was around his left cheekbone. He didn't complain of pain to the area but once again he is declining so I don't know if he could.On 4/29/26 at 12:50 PM, V13 (RN) said, I was passing medications in one of the other resident rooms, I heard the CNA who was coming out of the elevator yell. She saw an incident between [R1] and [R2]. She said one resident was hitting the other resident and she ran over to separate them and prevent further contact between the two. That was around 7PM.The facility's policy and procedure revised 2/25/26 showed, Abuse, Neglect and Exploitation. Policy: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Abuse means the willful infliction of injury. which can include staff to resident abuse and certain resident to resident altercations. The facility will develop and implement written policies and procedures that: a. Prohibit and prevent abuse.