STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145434	A. Building B. Wing	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Claridge Healthcare Center	700 Jenkisson Lake Bluff, IL 60044

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. (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	Based on interview and record review the facility failed to ensure a resident was free from resident-to-resident physical abuse for 1 of 7 residents (R4) reviewed for abuse in the sample of 7. Findings Include:On 9/2/25 at 12:50 PM, V3 (Assistant Director of Nursing) said there was an altercation that had just occurred between two residents {R4 and R5} and one of the residents was punched in the face and was just sent to the hospital because he had a small laceration on the side of his eye.R4's face sheet shows he has diagnoses including Alzheimer's disease, muscle weakness and abnormality of gait and mobility. R4's active care plan last revised on 7/8/25 shows he is alert but confused and forgetful, uses a wheelchair for mobility and his primary language is Spanish. The same care plan also shows that R4 is at risk for abuse due to wandering behaviors and having a cognitive impairment, dementia, with a language barrier. Interventions listed in R4's care plan is for redirecting his behaviors and engaging him in activities.R5's facesheet shows he has a diagnosis of dementia. R5's care plan initiated 7/21/25 shows he is ambulatory and alert but forgetful at times.A Nurses Progress note completed on 9/2/25 at 3:55 PM, by V12 (Registered Nurse) states, resident had physical contact with another resident, separated right away, noted bleeding to his face, completed entire physical exam, 1 cm laceration noted on left temple. sent resident to {local hospital} via ambulance at 12:45 PM.A Social Services note completed by V9 (Social Worker) on 9/2/25 at 5:07 PM states, Around 12:10 pm, this writer responded to a call for help from {R5's} room made by CNA (Certified Nursing Assistant) (V13). Upon arrival, this writer observed that the resident {R4} was being physical attacked by another resident {R5} on the floor. CNA and maintenance staff were attempting to separate the residents, this writer also intervened, but the aggressor continued hitting until staff successfully separated them and moved each resident to different rooms.On 9/2/25 at 1:17 PM, V12 said around 12:10 PM she heard screaming and ran towards the sound and found R4 and R5 in a physical altercation and R4 was being hit by R5. V12 said R4 has wandering behaviors and propels himself into other resident rooms all the time. V12 said both residents have dementia, and R4 also has a language barrier so he does not always understand what people are saying to him.On 9/2/25 at 1:22 PM, V13 said she heard yelling and when she got to the room, she found R4 and R5 in an altercation and grabbing at each other and she yelled for help. V13 said she attempted to separate the residents and did not physically see R5 hit R4 but R4 had blood on the side of his face after. V13 said R4 does wander around the unit in his wheelchair and needs redirecting. On 9/2/25 at 1:25 PM, V14 (Lake County Sheriff Officer) was interviewing R5 and came out of the room and said from what he gathered happened was that R4 had went into R5's room and was going through drawers. R5 wanted R4 out of his room and was yelling for him to get out of here, R4 did not leave and R5 ended up hitting R4. V14 said R4 then grabbed R5's shirt and it continued to escalate.On 9/2/25 at 1:27 PM, R5 said he hit R4 because he would not leave his room. R5 said he comes into the room all the time and this time he was not leaving so I hit him yes, and I meant to.On 9/2/25 at 1:30 PM, R7 (R5's roommate) said he did not see the altercation happen because he was at lunch, but he heard the yelling. R7 said the other guy (R4) comes into our room all the time and eats jelly off my nightstand, usually he leaves on his own. An incident/occurrence report form dated 9/2/25 shows that R4 returned to the facility on 9/2/25 at 4:00 PM, he was stable and had steri strips to his left temple, the local hospital had completed a CT/computed tomography scan of the spine and head which were negative for any bleed or fractures, R4 did not require sutures to the laceration. Hospital documents show R4 was diagnosed with a facial contusion. On 9/3/25 at 8:45 AM, R4 was sitting in the dining area at a table, his left eye was dark purple and very bruised around the eye socket. The sclera of his eye was red in color, and he had several steri strips to the outer temporal area of the left eye. R4 said, I am okay. When this surveyor attempted to talk to him. He also said no when asked if his eye was hurting him. On 9/3/25 at 8:47 AM, V20 (CNA) said she was here the day prior when the altercation happened. V20 said staff were in the dining room feeding residents and V5 came into the room saying someone needs to get him out of my room. V20 said she told another CNA to go see what was going on and the next thing she knows it had escalated, and they were fighting. V20 said R4 goes in and out of the other resident rooms frequently but will usually come right out because he is confused about which room is his.On 9/3/25 at 11:07 AM, V1 (Administrator) said when a resident hits another resident it is abuse.The facility provided Abuse Prevention Program policy last revised on 7/30/12 shows that the facility will prevent abuse, neglect and theft by establishing a sensitive and secure environment and all residents have the right to be free from abuse. The policy describes physical abuse as hitting, slapping, pinching, kicking or

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review the facility failed to ensure a resident was free from misappropriation of resident property for 1 of 4 residents (R1) reviewed for misappropriation in the sample of 7. Findings Include:An Illinois Department of Public Health Investigation Report completed by V3 (Assistant Director of Nursing) on 8/21/25 shows that R1 had reported that $300 was missing from her wallet. The report shows that R1 had taken a nap between 1:30-5:00 PM and when she woke up to take her medication, she noticed her wallet was not secured and the envelope she had inside it with her money was gone. The report shows that R1 is alert and oriented x 4 and cooperative.A Nursing Progress Note completed by V17 (Registered Nurse) on 8/20/25 at 10:30 PM for R1 states, Resident reported to nursing assistant that she lost $300.00 between 1 PM and 5 PM. R1's Social Service Notes for 8/21/25 show that V9 (Social Worker) went to meet with R1 on 8/21/25 at 9:30 AM, a room search was completed, and the money was not located. The police were contacted and came to the facility to interview the resident. A second social service note completed by V22 (Social Worker) on 8/21/25 at 8:18 PM, shows that R1 told V22 that she seldom leaves her room, and her wallet was inside her walker. V22s note shows R1 said she takes her walker everywhere with her even to the bathroom. R1 did not verbalize any suspects to V22 based on the progress note. On 9/2/25 at 8:38 AM, R1 was in her room, her walker which has a seat you can lift and store items underneath it was at her bedside. The top drawer of her dresser was noted to have a silver lock on it. R1 told this surveyor that she is very hard of hearing, and she must read lips to communicate. She said on 8/20/25 she had her wallet closed and inside her walker hidden under some other items she keeps in there. R1 had approximately $300.00 inside and she knows exactly what denominations of bills they were 3- $50.00 dollar bills, 4- $20.00 dollar bills, 3- 5.00 bills and a few $1.00 bills. R1 said she had taken money out of her account back in May to go out with her niece and she also takes $30.00 a month out of the account managed by the facility. R1 also said she had received $50.00 cash in the mail from her cousin for her recent birthday. R1 said she has not been out of the facility beside one doctor appointment since May 2025. R1 said she had taken a nap on 8/20/25 from about 1-5 PM. When she woke up, she noticed that the side of her walker seemed to be bulging out, so she opened the storage seat and her wallet, which was buried under other items, was sticking out and not closed. R1 said she opened the wallet up and all that was left was $3.00. R1 said she immediately panicked and began looking for her CNA that evening (V19), but V19 was on break so she waited for her to return from break and then told her about her missing money. R1 also said she seldom leaves her room and if she does her walker goes with her. R1 said she does have a locked drawer, but she had been keeping the wallet in her walker because nothing like this has ever happened before and she was too trusting. R1 was interviewed again by this surveyor on 9/3/25 at 10:20 AM and she described all the same events with her missing money.On 9/2/25 at 3:10 PM, V19 said R1 did report to her that she had money missing from her wallet. V19 confirmed that R1 seldom leaves her room and if she does her walker goes with her. V19 said R1 is alert and oriented and hard of hearing and if she is asleep, she would not hear someone enter her room. V19 said on the floor R1 resides on they do not have wandering residents. V19 said she went and told her nurse (V17) that evening about the missing money. On 9/3/25 at 8:08 AM, V11 (Administrator Assistant/ Business Office) said I did give money to R1 and brought in a transaction report showing R1's account that the facility manages. The report showed that R1 had taken out cash withdrawals of $30 on 5/6/25, 6/30/25, 7/4/25 and 8/21/25 and a cash withdrawal of $150 on 5/20/25. V11 said she encourages residents to not keep that much cash on them and knew that R1 had taken $150.00 out in May to go shopping with family so she waited until right before they were going to go to give her the money. V11 verified it was possible for R1 to have had that much cash on her possession. On 9/3/25 at 8:15 AM, V3 said she was alerted to R1's missing money on 8/21/25 and they did do a room search and the money was not located. V3 said R1 is deaf and does read lips and if someone came into her room while she was asleep, she would not hear them. V3 confirmed that R1 does not go out of the facility very often and that she is alert and oriented. V3 also confirmed when she interviewed R1 on 8/21/25 that her account of what cash she had, and the events matched what R1 reported to this surveyor. On 9/3/25 at 11:07 AM, V1 (Administrator) said they encourage residents to not have that much cash on them. V1 said he is highly upset that R1 had her cash taken from her and that they facility does not have cameras to identify who may have done it.The facility provided Abuse Prevention Program policy last revised on 7/30/2012 shows residents have the right to be free from misappropriation/theft and any missing money should be treated as theft until there are clear indications the

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review the facility failed to ensure the abuse coordinator was immediately notified of an allegation of misappropriation of resident property for 1 of 5 residents (R1) reviewed for abuse reporting in the sample of 7. Findings Include:An Illinois Department of Public Health Investigation Report completed by V3 (Assistant Director of Nursing) on 8/21/25 shows that R1 had reported that $300 was missing from her wallet.A Nursing Progress Note completed by V17 (Registered Nurse) on 8/20/25 at 10:30 PM for R1 states, Resident reported to nursing assistant that she lost $300.00 between 1 PM and 5 PM. On 9/2/25 at 3:10 PM, V19 said R1 did report to her that she had money missing from her wallet. V19 said she went and told her nurse (V17) that evening about the missing money. On 9/2/25 at 12:45 PM, V3 said she was not alerted to R1's missing money until 8/21/25 and when an allegation is made staff should notify an administrator or V1(Administrator and abuse coordinator) immediately. On 9/2/25 at 3:02 PM, V17 said he was alerted by a CNA, V19 the evening of 8/20/25 that R1 had money missing from her wallet but it was getting late in the evening, so he did not call anyone he just left a message to pass on in report to have social services see her the next day. V17 said he knows that you should call the abuse coordinator right away for any abuse allegations, but he thought they should wait to see if the money turns up. On 9/3/25 at 11:07 AM, V1 (Administrator) said staff are required to report to the abuse coordinator or a member of management who would then call the abuse coordinator immediately for any allegations of theft, misappropriation, abuse etc. V1 said waiting until the next day is not acceptable. The facility provided Abuse Prevention Program policy last revised 7/30/2012 shows that any allegations of abuse or mistreatment including misappropriation of property should be reported to a supervisor who should immediately report it to the administrator.