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	09/12/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to implement interventions for a resident at risk for elopement to elope from the facility. These failures resulted in R1 eloping from the facility and being found walking in the road of a heavily traveled highway. This applies to one of three residents (R1) reviewed for safety in the sample of three. This failure resulted in an Immediate Jeopardy. The Immediate Jeopardy began on 9/7/25 when staff were unable to locate R1 inside the facility. V2 (Director of Nurses) was notified of the Immediate Jeopardy on 9/12/25 at 9:50 AM. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed on 9/12/25, but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-servicing training. Findings IncludeThe facility's initial incident report sent to the IDPH (Illinois Department of Public Health) showed R1 was observed through a window in the facility parking lot on 9/7/25 at approximately 8:00 AM. Staff went outside to look for the resident and were unable to locate the resident. The report showed staff called the local police department at 8:16 AM. The report showed R1 was found by local police and returned to the facility at 9:55 AM. R1's face sheet printed on 9/11/25 showed diagnoses including but not limited to psychosis, malnutrition, physiological condition, insomnia, and need for personal care. The same face sheet showed R1 has resided on the second floor of the dementia unit since admission in May of 2024. R1's facility assessment dated [DATE] showed severe cognitive impairment and the ability to walk independently with staff supervision. R1's elopement risk assessment dated [DATE] showed R1 was not physically able to leave the building and was not confused or disoriented (conflicts with the facility assessment). On 9/11/25 at 9:45 AM, R1 was seated in an upright chair in the hallway, directly outside of his room. R1 was pleasantly confused and could not provide any details regarding his elopement. R1 answered yes or no to all questions in a nonsense manner. On 9/11/25 at 9:50 AM, V3 (Licensed Practical Nurse) stated R1 recently went onto the elevator alone and went outside. V3 stated he was trying to look for his mother. The elevator has a key card needed to open the doors but sometimes it doesn't work if the battery is low. V3 said sometimes the doors don't close right away and residents can slip out onto the elevator. V3 said we try to always have someone right by the doors to watch for that. I guess no one was watching the day R1 got out. On 9/11/25 at 10:00 AM, V1 (DON-Director of Nurses) stated she was at the facility the morning R1eloped. R1 said the second-floor nurse (V4) called her and said R1 was observed by V5 (CNA-Certified Nurse Aide) alone outside. V1 said she ran outside but did not see any sign of R1. V1 said she drove her car around the neighborhood then called 911 about 15 minutes later. V1 said R1 can walk without assistance, does not understand English, and is very confused. V1 said she spoke with a local police officer at a nearby gas station. She was told they were in the process of searching the neighborhood for R1 too, so she returned to the facility. V1 said she began looking inside parked cars and came upon a visitor sitting in his car. V1 said the visitor told her he saw a resident come outside and walk behind the building, toward a wooded area. V1 said she searched there and still could not locate R1. V1 said multiple police officers and dogs arrived and continued to search the area. V1 said she received a phone call approximately one hour and forty minutes later that R1 had been found. V1 said the second-floor dementia unit is a locked unit and everyone needs a key card to activate the security pad for the elevator. The security pad was not working last Sunday (9/7) and that is the only way R1 could have got outside. It has been broken a couple of weeks now. V1 said currently, she sits at the nurse's station and watches the elevator when staff aren't there. V1 said she should have been watching the elevator when R1 got out, but she was up and down on other floors that morning. The visitor that observed R1 wandering in the parking lot was attempted to be interviewed but could not be reached during this survey. On 9/11/24 at 10:52 AM, V4 (RN-Registered Nurse) stated she was notified that R1 was outside of the building alone by V5 (CNA) during the breakfast meal on 9/7/25. V4 stated she ran to a window and saw R1 wandering in the parking lot. V4 said she immediately called the DON and reported the elopement. V4 said no one was watching the second-floor elevator or the first-floor front desk. V4 stated the elevator usually needs a key card to open the doors but it hasn't been working for a few weeks. V4 said there is usually a receptionist at the front door, but no one was working that day. V4 said we are supposed to have someone watching the doors to keep residents from getting out. V4 said R1 must have just pushed the elevator, got on, and walked out the front door all by himself. R1 is not fully alert or oriented. He does not speak English and only understands yes or no questions. On 9/11/25 at 11:08 AM, V5 (CNA) said she was