

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145434	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/05/2026
NAME OF PROVIDER OR SUPPLIER Claridge Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure a resident did not elope from the facility's locked unit, failed to update the list of residents at risk for elopement, and failed to update a resident's care plan after an elopement for 1 of 3 residents (R1) reviewed for safety and supervision in the sample of 3. The findings include: On 1/5/26 at 10:32 AM, R1 was standing in the common area near the elevator talking loudly. The elevator door was opening frequently, and staff/visitors were entering and exiting. The staff had to use a fob to request the elevator. At 11:40 AM, this surveyor requested to see the list of residents at risk for elopement from V10 (Licensed Practical Nurse). V10 said that there is usually a list hanging at the nurse's station, but she could not find it. V10 then found a binder and opened it up and there was an elopement risk list inside the binder. The list was last updated on 11/19/25 and R1 was not on the list. V10 wrote R1's name on the list. R1's Face Sheet shows that she was admitted to the facility on [DATE] with diagnoses of schizophrenia, anxiety and depression. R1's Hospital History and Physical dated 11/27/25 shows, Upon examination, patient is irritable, racial slurs. States she is here because I wanted to go to the store, I called my husband, and he said I could go but they wouldn't let me at the nursing home, so I tried to leave anyway. Delusions and paranoia are present. R1's Social Service Note dated 12/2/25 shows, Resident is a [AGE] year-old female, who is ambulatory. Resident was noted aggressive, with threats, gestures and behaviors for at least 2-3 hours on the unit this evening and she is considered to be at high risk for leaving the facility unattended. R1's Incident Note dated 12/12/25 at 9:20 AM shows, Staff were alerted that resident had left the building unauthorized. Staff went to catch up to the resident one staff by walking, and two staff took their car to follow her. Staff were able to catch up to her at the first stop sign. On 1/5/26 at 10:30 AM, V8 (Receptionist) said that on 12/12/25 at 9:00 AM, V9 (Certified Nursing Assistant) and R1 came down to the 1st floor for smoke break. V8 said that R1 did not have any cigarettes at reception so V9 and R1 returned to the second floor to retrieve them. V8 said that a short time later, R1 arrived at the reception area unattended. V8 said that R1 asked him for a cigarette, and he told her that he did not have any. V8 said that he paged the 2nd floor staff to come down and get R1 but R1 exited the building through the front door before they arrived. V8 said that he called for help and V4 (Administrative Assistant) responded and went after R1. On 1/5/26 at 10:12 AM, V7 (Maintenance) said that he heard that R1 had left the building, so he started running after her. V7 said that he caught up to R1 when she was already out of the parking lot and almost to the first stop sign on the road (approximately 0.2 miles). V7 said that he tried to convince R1 to return to the facility, but she would not and said that she was going to court. V7 said that he continued to walk with her until the police arrived (approximately 0.8 miles from the facility). On 1/5/26 at 10:19 AM, V6 (Registered Nurse) said that on 12/12/25, she was working as the nurse on the second floor. V6 said that she typically does not work the second floor, so she was</p> <p>(continued on next page)</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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>not familiar with R1. V6 said that right before R1 eloped, she saw R1 talking to V11 (Psychiatric Nurse Practitioner). V6 said that she was passing medications and V8 called her and said that R1 was on the first floor. V6 said that she is not sure how R1 got to the first floor. On 1/5/26 at 10:55 AM, V9 (Certified Nursing Assistant) said that on 12/12/25, she brought R1 and another resident down to the first floor to smoke but they both did not have any cigarettes, so she brought them back up to the second floor and continued taking care of other residents. V9 said that she then heard that R1 had left the facility. V9 said that she does not know how R1 got to the first floor on her own. On 1/5/26 at 11:00 AM, V10 (Licensed Practical Nurse) said that R1 is only allowed to go off of the second floor with a staff member. V10 said that the elevator requires a fob to be used from the second floor. V10 said that there is usually a staff member at the nurse's station watching to ensure that residents do not enter the elevator without a staff member. V10 said that if she has to leave the nurse's station, she will get another staff member to sit at the station to watch the elevator. V10 said that R1 is at risk for elopement and is not in touch with reality. On 1/5/26 at 12:54 PM, V2 (Director of Nursing) said that all residents have an elopement assessment done upon admission and if they are at risk for elopement, they place them on the second floor. V2 said that the second floor is a locked unit, and residents should not be able to exit the unit without staff assistance. V2 said that a staff member should be present at the nurse's station at all times to ensure that residents do not get on the elevator unattended. On 1/5/26 at 1:01 PM, V3 (Assistant Director of Nursing) said that the second floor is the locked unit, and residents should not be able to exit the floor without a staff member. V3 said that she is not sure how R1 got on the elevator on her own. V10 said that they try and have a staff member watching the elevator and keep the residents who are at risk for elopement away from the elevator and involved in an activity. At 2:11 PM, V10 said that after an elopement, the resident's care plan should be updated by social services. V10 reviewed R1's Care Plan and said that she did not see an update after R1 eloped. V10 said that an in-service was not done after R1's elopement. On 1/5/26 at 1:34 PM, V11 (Psychiatric Nurse Practitioner) said that R1 is at risk for elopement. V11 said that on 12/12/25 she saw R1 and was walking the unit and talking with her. V11 said that after she was done on the second floor, a nurse used their fob to open the elevator, and she went to the third floor. V11 said that R1 was in the common area near the elevator when she left the second floor. V11 said that she was on the third floor for some time before she heard that R1 had left the facility. R1's Elopement Risk Evaluation dated 12/2/25 shows that she is at risk for elopement. R1's Care Plan printed on 1/5/26 shows that R1 is an elopement risk/wanderer related to history of attempts to leave facility unattended, impaired safety awareness, wanders aimlessly and is extremely unhappy being in a nursing home. R1's elopement interventions include disguise exits, distract resident from wandering by offering pleasant diversion, structured activities, food, conversation, television, book. All interventions were initiated on 12/2/25. No additional interventions were added after her elopement on 12/12/25. The list titled Residents with Risk for Elopement/Wandering was provided. The list was last updated on 11/19/25 and had 13 residents listed. R1 was not listed on the list. The facility's undated Missing Person/Elopement Policy shows, Safety of all residents is the primary care standard at [Facility]. Precautions, procedures, staff and visitor education have been put in place to maximize resident safety. A Resident Elopement form and a thorough investigation will be completed by the Nurse Manager. He or she is responsible to instruct staff on precautions and safety measures to be taken. The responsible nurse manager will attend the committee meeting to further review the incident and to develop a plan to prevent recurrence. In-service will be conducted on the day of the elopement occurrence to implement safeguards against repeated occurrences. The</p> <p>(continued on next page)</p>		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility's Elopement/Missing Resident Policy revised on 9/12/25 shows, The elopement risk assessment will be competed upon admission, quarterly and with change of condition by social service department. A care plan will be developed and updated upon admission, quarterly and with change of condition by the social service department. Social Services or their designee will In-service and inform all staff members of any residents at risk for elopement and will be updated on any new interventions and any new residents added to the elopement book.		