

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  03/19/2026
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 - Immediate jeopardy to resident health or safety</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure a resident with a history of elopement and identified as high risk for elopement was provided adequate supervision to prevent elopement and failed to ensure an exit door alarm was alarmed. This failure resulted in R1 eloping from the facility without being witnessed on 3/11/26 being found about 1.6 miles away having crossed three busy heavily traveled roads. This applies to 1 of 3 residents (R1) reviewed for safety supervision in the sample of 3. This failure resulted in immediate jeopardy. The Immediate Jeopardy began on 3/11/26 when staff were unable to locate R1. V1 (Administrator) was notified of Immediate Jeopardy on 3/17/26 at 3:15 PM. This surveyor confirmed by interview and record review that Immediate Jeopardy was removed on 3/19/26 but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. The findings include: On 3/17/26 at 9:40 AM, V3 (Assistant Director of Nursing) said R1 eloped from the facility on 3/11/26 and had a history of eloping from the facility doing so in September of 2025. R1 resided on the second floor that was a locked unit and a card key was needed to use the elevator. V3 added that no one witnessed R1 exiting the building and they were not sure how he exited the building. V3 said she thought R1 entered the elevator when someone exited the elevator while the doors were still open. V3 added that no door alarms were noted alarming around the time R1 eloped. A facility incident report with an occurrence date of 3/11/26 showed the following: R1 was last seen on 3/11/26 at 11:30 AM, a certified nursing assistant went to get R1 at 11:50 AM, the certified nursing assistant could not find R1, a facility search was done and R1 was not located. The same document showed 911 was called and the sheriff department found R1 at 1:27 PM (1 hour and 37 minutes after R1 was noted as missing) on route 176. On 3/17/26 at 10:41 AM, V5 (Registered Nurse) said on 3/11/26 at 11:50 AM V6 (Certified Nursing Assistant) went to get R1 for lunch and R1 could not be found. V5 said they searched the facility, including outside of the facility, and they were unable to locate R1. V5 said during the search she checked the basement exit door and it did not alarm. V5 added that she thought R1 got on the elevator when someone exited the elevator while the elevator doors were still open. V5 said she did not hear any door alarms prior to noticing R1 was missing. V5 said R1 was wearing pants and a windbreaker. R1's progress note dated 3/11/26 entered by V5 showed the facility was searched and R1 was not found. The same note showed the basement exit door did not alarm when opened. On 3/17/26 at 10:48 AM, V6 confirmed on 3/11/26 at 11:50 AM she went to get R1 from his room and could not find R1. R1 said she did not hear any door alarms around the time frame R1 eloped. On 3/17/26 at 10:59 AM, V9 (Receptionist) said on 3/11/26 he was at the main desk on the ground floor that faces the elevator doors and did not see R1 exit the elevator or the main exit. V9 added that he did not hear any door alarms around the time frame R1 eloping. A Sheriff's Office Field Case Report dated 3/11/26 showed R1 went missing from the facility on 3/11/26 at 11:30 AM. A local oil change shop called saying a man matching R1's description had been at the shop and seemed, .confused. The same report indicated R1 was wearing a windbreaker jacket, and it was 33 degrees Fahrenheit outside. The report showed R1 was found at a scrap metal facility. (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 - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 3/17/26 at 12:05 PM, V8 (local Oil Change Shop Employee) said a man matching R1's description arrived at their oil change shop on 3/11/26 around 11:50 AM. V8 said R1 seemed confused as he did not know where he was and was asking for directions to a town. V8 said R1 was not dressed for the cold weather as R1 had on a windbreaker, t-shirt, jeans, and shoes. V8 said R1 wandered off and they called 911. The National Weather Service website showed on 3/11/26 at 11:51 AM the temperature was 34 degrees Fahrenheit. On 3/17/26 at 1:10 PM, V7 (Police Officer) said R1 was found at a scrap metal recycling center (1.6 miles away from the facility). V7 said for R1 to get to the location where R1 was found, R1 had to of crossed three busy roadways that are heavily traveled. V7 added that R1 was taken to the hospital and evaluated for cold exposure. R1's hospital discharge paperwork dated 3/11/26 showed he was evaluated in the emergency room for cold exposure. On 3/17/26 at 11:50 AM, V10 (R1's Doctor) said R1 was confused and if R1 leaves the facility R1 should have someone with him as he needed supervision for safety reasons. On 3/17/26 at 12:26 PM, R1 said he did not remember going outside on 3/11/26. R1 added he never goes outside. R1 was confused as he was unable to say where he was or give the date/time. R1's Care Plan printed on 3/17/26 showed he eloped from the facility on 9/7/25, 3/11/26, and was at risk for elopement. The care plan also showed R1 was at risk for falls, had impaired cognitive functions/dementia, impaired thought processes/decision making with poor short term and long-term memory loss. R1's elopement care plan showed R1 will not leave the facility unattended without staff supervision. R1's Elopement Risk Evaluation done on 12/28/25 showed R1 was at risk for eloping. A facility assessment done on 12/21/25 showed R1s cognitive status was severe impairment. R1's Psychiatrist Physician Note dated 3/8/26 showed R1 had a history of auditory hallucinations. On 3/17/26 at 11:53 AM, V4 (Maintenance) checked the basement exit door (the same door V5 said did not alarm when V5 was searching for R1 on 3/11/26). The alarm did not activate when the door was opened by V4. V4 said someone must have turned off the alarm and the alarm should have been activated. V4 said he was not aware the exit door alarm was not alarmed on 3/11/26. The facility presented an abatement plan to remove the immediacy on 3/19/26 at 10:03 AM. The abatement plan was reviewed and was unable to be accepted. The abatement plan was returned to the facility for revisions on 3/19/26 at 11:40 AM. The facility presented a revised abatement plan on 3/19/26 at 12:58 PM. The abatement plan was reviewed and accepted on 3/19/26 at 1:47 PM. The Immediate Jeopardy that began on 3/11/26 was removed on 3/19/26 when the facility took the following actions to remove the immediacy: 1. The facility policy on Elopement Risk: The Policy and Procedure for Elopement Risk residents will be used to identify the potential for residents to exit unsupervised from the facility. The Elopement Risk Assessment will be completed by Social Service Department upon admission, quarterly and with change of condition. This policy was revised on 3/17/26. R1 Social Service Unauthorized Departure / Elopement Risk Assessment has been done on 3/11/26. R1 Care plan was updated on 3/11/26. On 3/12/26 R1 was re-assessed by the psychiatrist NP increased R1 medication (olanzapine) to twice a day. On 3/12/26 R1. had a room change from room [ROOM NUMBER] to room [ROOM NUMBER] (closer to nursing station) to closely monitor. On 3/12/26 R1 was placed on hourly safety checks.3. All residents at risk will be reviewed and a revision of the Elopement Book and care plan update will be completed by the Social Service Department. Residents with Elopement Risk will be monitored on an individualized basis dependent on their risk assessment. Social Service will do continued training for all staff on elopement risk residents and any changes to the care plan will be completed at the time the elopement risk book is updated with any changes in residents' appearance and condition. This was completed on 3/19/26.4. Starting on 3/19/26 2nd floor staff will alternate desk coverage to monitor the elevator to prevent residents from entering the elevator. On the 2nd floor, staff will be required to fill in the sign-in /sign-out sheet to ensure the area is covered 24 hrs a day indefinitely. The floor nurse will be assigned to check the emergency exit doors to ensure they are working properly by opening the door and hearing the alarm, then re-set the alarm door with the key this action will be done 2 times per shift. If the emergency doors do not sound, the floor nurse will be responsible (continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>for notifying the Maintenance Department immediately. All exit doors to the outside will be tested daily by Maintenance Department to ensure the exit doors are armed and will sound when opened.5. On 3/19/26, In-services began on the updated Elopement Risk Policy and Procedures and the Elopement Risk Book to educate all staff including nursing (Nurses and CNAs), Administration, Front Desk, Dietary, Activities, Housekeeping, Maintenance and Laundry. The above staff will continue to be in-serviced on following the Elopement Risk policy and procedures, the Elopement Risk Book and the plan for 2nd floor staff monitoring the elevator, the emergency exit doors and the exit doors to the outside. This will be completed prior to the start of their shift, via group in-service or one on one in-service, given by nursing administration. All in-servicing will be completed by 3/25/26.6. Effective today random audits of the all sign-in logs for the elevator, emergency exit doors on the unit and exit doors to the outside will be completed daily by the DON or her designee this process will continue for three months to ensure the procedure is being completed. The Medical Director has been informed and will be involved in the Quality Assurance. Progress will be reviewed and discussed at the quality assurance meeting to ensure corrections are achieved and permanent.</p>		