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	06/15/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to immediately activate emergency medical services (EMS) for a resident who fell approximately 20 feet from a second story window and failed to ensure the resident remained immobilized and inappropriately moved the resident prior to receiving the necessary care and services. This applies to 1 of 5 residents (R1) reviewed for necessary care and services. The findings include: R1's face sheet shows she is [AGE] year-old female admitted to the facility on [DATE] with diagnoses including Alzheimer's, unspecified Psychosis, Dementia unspecified severity with agitation, Major Depressive Disorder. R1's Incident Report dated 6/6/26 shows on 6/6/26 at 10:50 PM, R1 was not located in her room. A building search was conducted inside and outside of the building. R1 was found by staff on the ground outside of the building in the yard underneath her 2nd floor bedroom window. R1 was brought back to her room by staff, 911 emergency services were contacted and sent to local hospital. R1's hospital records dated 6/6/26 show R1 presented as a Level 1 trauma after falling approximately 20 feet from a second-floor window and sustained multiple injuries to her body. R1 sustained C1 fracture, T3 bust fracture (severe injury where the vertebra loses height in both the front and the back. Typically caused by high energy trauma like a car accident or severe fall), right anterior 3-8 rib fractures, left 4-7 fracture, pneumothorax, pelvic fracture, and right adrenal hemorrhage. On 6/9/26 at 9:10 AM, V2 (Director of Nursing-DON) said on 6/6/26, she was in the facility and received a call from V4 (Registered Nurse-RN) they could not locate R1. V2 said she went upstairs and they started searching for R1 and could not find her. The night shift arrived and started looking outside for her. R1 was found lying on the ground outside where her room was. She was lying on her right side complaining of pain and short of breath. V2 said she told the staff to move her and get her back to her room. V2 said the staff rolled her on a blanket and carried her on the blanket back to her room on the 2nd floor. On 6/9/26 at 1:45 PM, V6 (RN) said on 6/6/26 he arrived at work on 3rd shift at 11:00 PM, they were trying to find R1. We looked outside and she was found at the back of the building lying on her right side on the ground below her room. V6 said I was not sure what happened and said we should call the ambulance. We need to call 911. V6 said V2 (DON) told the staff to move R1 back in her room. We rolled her on the blanket and carried her back to her room. R1 was complaining of pain to her chest and head. After they moved her upstairs then 911 was called. He (V6) did not think moving her was a good idea, it could cause more injury to the resident. On 6/10/26 at 11:12 AM, V3 (ADON) said a fall like that you should not move the resident. You could make the injuries worse. I almost fell out of my chair when I heard they moved her. On 6/10/26 at 11:30 AM, V2 (DON) said I should have not moved R1, but I was not thinking. V6 told me we should not move R1 and call 911 first. I was not thinking, it was a big mistake. When the paramedics came, she reported to them R1 was moved. On 6/9/26 at 1:24 PM, V12 (Medical Director) R1 sustained multiple fractures, brain bleed and Pneumothorax from falling out of the 2nd story window. She is lucky she did not sustain any permanent injuries. Residents should not be moved after a fall it could cause serious injuries. R1's nurses note dated 6/5/26 documents R1 was found outside on facility grounds. Staff brought her back to bed then called 911. The facility's undated Falls/Incidents Prevention Policy states, It is our goal to promote resident safety and (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	independence and to prevent life threatening dangers of falls.Upon discovering a resident's fall, staff will summon the nurse on duty who will assess the resident and determine the next action.the assessment will include a complete head to toe exam including vital signs, neurological checks and observation of any bleeding, pain, loss of consciousness, deformity, swelling.and/other indications of first aid is needed. If needed, first aid will be given immediately and procedure for utilizing 911 or activating emergency medical system will be followed.a resident whose head is stuck in a way should be sent to the ER.

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(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure a severely cognitively impaired resident with a known history of wandering and exit seeking behaviors was supervised to prevent elopement. This failure resulted in R1 eloping from a secure unit through her 2nd floor window and plummeting to the ground below. R1 was found approximately 20 feet from her window with her personal belongings scattered outside on the ground. R1 was sent to the local hospital sustaining multiple fractures, C1 fracture, Pneumothorax and a Subarachnoid and Subdural Hemorrhage (brain bleed). The Immediate Jeopardy began on 6/6/26 when R1 could not be located in the facility. R1 eloped from a secured unit out her 2nd floor window and plummeted to the ground below. At 11:25 PM, R1 was found approximately 20 feet from her window with her personal belongings scattered outside on the ground. V2 (Director of Nursing) was notified of the Immediate Jeopardy on 6/10/26 at 11:10 AM. This surveyor confirmed by observation, interview and record review that the Immediate Jeopardy was removed on 6/11/26, however noncompliance remains at Level two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. The findings include: R1's face sheet shows she is [AGE] year-old female admitted to the facility on [DATE] with diagnoses including Alzheimer's, unspecified psychosis, dementia unspecified severity with agitation, major depressive disorder. R1's preadmission records show she was hospitalized on [DATE] for wandering in the neighborhood with inappropriate behavior. Since arriving she is pacing back and forth, looking to exit out of the building. R1's EHR (Electronic Health Records) shows she wants to go home and was pointing to the window and says she lives near. R1's preadmission Psychiatric Evaluation dated 5/4/26 shows she is Korean speaking female who has increasing agitation and aggressiveness. She started leaving the home in the middle of the night, becoming very disorganized and quite labile. She started endangering herself as a consequence of her behavior. She has become delusional and quite dysphoric. She thinks she is endangered, and someone is trying to harm her. R1 has a past history of bipolar disorder, major neurocognitive disorder, Alzheimer's and anxiety. She has had 2 known psychiatric hospitalizations. These preadmission records were sent to the facility dated 5/22/26 to be reviewed prior to admission. R1's Incident Report dated 6/6/26 shows on 6/6/26 at 10:50 PM, R1 was not located in her room. A building search was conducted inside and outside of the building. R1 was found by staff on the ground outside of the building in the yard underneath her 2nd floor bedroom window. R1 was brought back to her room by staff, 911 emergency services were contacted and sent to local hospital. (R1's) behaviors included, restless, unable to make needs, known, memory impairment, history of wandering and wants to go home. R1 admitted with the diagnosis of critical polytrauma. R1's hospital records dated 6/6/26 show R1 presented as a Level 1 trauma after falling approximately 20 feet from a second-floor window and sustained multiple injuries to her body. R1 sustained C1 fracture, T3 bust fracture (severe injury where the vertebra loses height in both the front and the back. Typically caused by high energy trauma like a car accident or severe fall), right anterior 3-8 rib fractures, left 4-7 fracture, pneumothorax, pelvic fracture, and right adrenal hemorrhage. R1's Elopement Risk dated 6/4/26 shows she is at risk for elopement and had exit seeking behaviors. She has a history of elopement/attempted an elopement while at home, verbally expressing the desire to go home/or stayed near an exit door, wanders, has the physical ability to leave the building, becomes easily agitated/confused/disoriented and shows poor judgment.On 6/9/26 at 9:25 AM, V2 (Director of Nursing) showed this surveyor R1's broken screen from her window. The top of the screen was completely ripped off with the screen part hanging down. R1's room was located on the 2nd floor, the measurement from her window to the ground floor was approximately 25 feet. A chair was located next to the windowsill. An awning style window with hinges on the bottom and opens from the top (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	measured 15 inches in width when opened. R1's personal clothing was scattered on her bed with grass clippings. On 6/9/26 at 9:10 AM, V2 (DON) said on 6/6/26, she was in the facility and received a call from V4 (Registered Nurse-RN) they could not locate R1. V2 said she went upstairs, and they started searching for R1 and could not find her. The night shift arrived and started looking outside for her. R1 was found lying on the ground outside where her room was. R1's clothes and blanket were outside on the ground. She was lying on her right side complaining of pain and short of breath. R1's window screen was torn and that's the only way she got out through the window. V2 said she saw R1 when she made rounds at 9:30 PM. R1 was a new admit and had been at the facility for two days. R1 wandered, she was looking for an exit and repeated she wanted to go. R1 needed to be supervised frequently due to her behavior, but she did not think R1 would go out the window. On 6/6/26 at 10:32 AM, V4 (RN) said she was R1's nurse on 6/6/26 when she eloped. R1 was confused, delusional and had exit seeking behaviors during her shift. She was trying to exit through the emergency doors and trying to get off the elevator. Ever since her admission she had been exit seeking, it was bad. She saw R1 last about 8:30 PM when she was sitting at the nurse's desk. V2 came to floor around 9:30 PM, made rounds and said R1 was okay in her room. At the end of shift, she was making rounds with the CNA and that's when they could not locate R1. We searched everywhere in the facility and could not find her then we notified V2. Staff found her outside lying on the ground floor outside of her room. R1 was alert to self, complaining of upper chest pain and she was sent out to the local hospital. R1 was very suspicious, paranoid and we would have her sit at the nurse's station because she needed a lot of supervision. R1 was upset, she was at the facility and wanted to leave. She kept on asking the same questions repeatedly, she was difficult to re-direct and wanted to leave. She did not get much information in report about her past behaviors. R1 needed frequent checks, and we watched her and stayed with her when we could. On 6/9/26 at 11:06 AM, V5 (Licensed Practical Nurse-LPN) said she was R1's nurse during the day shift on 6/5/26 and 6/6/26. R1 was confused, she had exit seeking behaviors and was trying to leave through the exit doors and elevator. V5 said she tried to keep R1 at the nurse's station due to her behavior. R1 had a history of eloping and was at risk of eloping. R1 needed to be monitored closely she told the CNAs to check on her frequently. R1 knew this was place was not her home and that her daughter placed her here. Her will was so strong to get out of here. On 6/9/26 at 11:23 AM, V9 (Certified Nursing Assistant-CNA) said on 6/6/26 she was CNA on 1st and 2nd shift. She said she saw R1 last around 8:00 PM near the nurse's station. She did not know R1 was at risk for eloping or needed frequent checks. She saw R1 grab her clothing and looking to exit off the 2nd floor. R1 wanted to leave, and she told her No and reported to nursing. She said V2 asked her to monitor R1, she could not supervise her because she had other residents to take care off, it was very busy that day. On 6/10/26 at 11:42 AM, V9 (CNA) said on 6/6/26 she was the CNA on 1st and 2nd shift. R1 was newer resident, every time she would grab her clothes and was trying to leave off the elevator. She was trying to leave multiple times, it was reported to her this was her normal behavior. There was no direction to supervise her frequently. On 6/9/26 at 1:45 PM, V6 (RN) said on 6/6/26 he arrived at work on 3rd shift at 11:00 PM, they were trying to find R1. We looked outside and she was found at the back of the building lying on her right side on the floor below her room. R1 was in a lot of pain, she was complaining of chest and head pain. R1's screen was busted, I think she jumped out of the window. If a resident has exit seeking behaviors they need increased supervision, notify the physician and sometimes they require 1:1 supervision. On 6/9/26 at 1:16 PM, V11 (R1's Physician) said R1 has dementia, confused and had a history of exit seeking. She had a similar situation for a couple of months trying to leave a previous nursing home. She tried to leave through a window before, he recalls when reviewing her medical records. Then she was in patient psych for a couple of months and was placed on antipsychotic medications. Staff did not report to me she was exit seeking. If she showed signs of exit seeking, she would require increased supervision. On 6/9/26 at 1:24 PM, V12 (Medical Director) R1 sustained multiple fractures, brain bleed and pneumothorax from falling out of the 2nd story window. R1 is confused, has dementia and he would expect staff to increase (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	supervision and redirect when a resident has exit seeking behaviors. On 6/10/26 at 11:10 AM, V2 (DON) said she was not aware of R1's history of elopement and she did not review R1's past medical history. R1 required 1:1 supervision for safety. R1's nurses note dated 6/5/26 documents (R1) is confused and is looking for an exit. R1's physician progress note dated 6/5/26 documents she has a prior psych hospitalization for dementia and confusion, after she was found wandering in the parking lot of her apartment complex.R1 was sent to an extended long term care facility became aggressive and sent to psych hospital.she was found wandering again and sent to psych hospital. She became aggressive at the place trying to get out of the building.She is placing around and asking to discharge planning. She has poor insight, severe psychosis.monitor behavior. R1's current care plan initiated on 6/4/26 shows she is an elopement risk, could be at risk due to pacing and may require monitoring. She has a history of elopement. Interventions include conducting functional assessments to identify triggers and purposes of elopement. Increase supervision during known high-risk times and locations. Arrange environment to reduce opportunities of elopement. Provide structured activities. R1's care plan also shows she has the potential for verbal and physical aggression related to anger and poor impulse control. R1 has impaired cognitive function related to dementia. The facility's undated Elopement/Missing Resident Policy and Procedure States, The elopement risk assessment will be completed upon admission and quarterly and with the changes of condition.a care plan will be developed and updated.staff members will make random checks to verify residents are in the facility. If the event of a missing resident, the nurse on duty shall announce CODE BLACK; notify the administrator and the Director of Nursing. The facility's undated Wandering & Exit Seeking Policy states, The purpose of this policy is to reduce the risk of elopement and ensure individual safety through prevention, supervision, and intervention strategies. Possible triggers: The individual may attempt to elope when: Experiencing anxiety or frustration.Wanting to go home, seeking family.Warning signs: Pacing unable to redirect, Expressing wanting to leave, seeking an exit, Increased agitation.Supervision plan: Level of supervision required, Keep resident in line of sight, Keep resident at arm's length. The facility presented an abatement plan to remove the Immediacy on 6/10/26. The survey team reviewed the abatement plan and was unable to accept the abatement plan to remove the Immediacy. The abatement plan was returned to the facility for revisions. The facility presented a revised abatement plan on 6/11/26. The Immediate Jeopardy that began on 6/6/26 was removed on 6/11/26 when the facility took the following actions. Facility plans for removal for Immediate Jeopardy related to failure to ensure a severely cognitively impaired resident with a known history of wandering and exit seeking behaviors were supervised to prevent elopement. 1.The facility Policy and Procedure for Exit Seeking / Wandering Behavior will be used to reduce the risk of Unauthorized Departure / Elopement and ensure safety through prevention, supervision and intervention for residents seeking unsupervised exit from the facility. This policy will be initiated on 6/11/26.2.R1. Social Service Unauthorized Departure / Elopement Risk Assessment has been completed on 6/10/26. R1 Care plan has been updated on 6/10/26. Upon return R1 will have a room change from room [ROOM NUMBER] to room [ROOM NUMBER] (closer to nursing station) to close monitor. Upon R1 return from the hospital, R1 will be reassessed by the psychiatrist NP for any adjustment in medication. R1 will be placed on hourly safety visual checks. If R1 behavior of exit seeking escalates the visual checks will be adjusted to 30 min intervals. If R1 is seen with increased agitation and pacing 1:1 attention will be provided. 3.All residents will be reviewed, and The Unauthorized Departure / Elopement Risk Assessment will be updated by the Social Service Department by 6/19/26. 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 will be completed by 6/19/26.4.On 6/11/26, In-services began on the Dementia Wandering and Exit Seeking Plan to educate all staff including nursing (Nurses and CNAs), Administration, Front Desk, Dietary, (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Activities, Housekeeping, Maintenance and Laundry. The above staff will continue to be in-serviced on the following Dementia Wandering and Exit Seeking Plan. The 2nd floor staff will continue to monitor the elevator and the emergency exit doors. All staff will be in service prior to the start of their shift, via group in-service or one on one in-service, given by Nursing Administration. When a resident begins to experience increased exit seeking behaviors the nurse on the floor will notify the front desk, the Physician and the psychiatrist NP.All in-servicing will be completed by 6/15/26. 5.Effective today, random audits of all sign-in logs for the elevator, emergency exit doors on the unit, hourly check, and agitation exit seeking behavior will be done daily by the [NAME] 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 Quality Assurance. Progress will be reviewed and discussed at the quality assurance meeting to ensure corrections are achieved and permanent.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on interview and record review, the facility failed to ensure the administrator provided the necessary oversight and management to ensure the facility operated effectively for the health, safety and well-being of all residents. This applies to all residents residing in the facility. The findings include: The facility census dated 6/9/26 shows 77 residents residing in the facility. This surveyor was in the facility on site from 6/9/26 to 6/11/26. On 6/9/26 at 3:00 PM, V1 was notified of the serious concern of R1 eloping from her 2nd story window and sustaining serious injuries. V1 was not aware of R1's history of eloping and asked to define an abatement plan. V1 was not present on 6/10/26 when the Immediate Jeopardy-IJ was declared for a resident eloping out of a 2nd story window and sustaining several fractures, C1 fracture, pneumothorax and brain bleed. On 6/11/26, V1 was not present and nor involved composing the removal plan and oversight during the Immediate Jeopardy. On 6/10/26 at 2:00 PM, V3 (ADON) said V1 was not coming in today and she was working on the removal plan for the IJ. On 6/11/26 at 10:00 AM, V3 (ADON) said V1 was not coming in today. He is not involved with the removal plan. V3 said this is the facility's third IJ for elopement in one year. The facility's previous IJ was in March 2026. The facility's undated Job Description Administration states, The Administrator is responsible for planning, organizing, staffing, directing, coordinating, reporting, budgeting, and physical management of the facility, residents, employees and equipment in way the purpose of the facility shall be established and maintained in accordance with established policies.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on interview and record review the facility failed to review and update the Facility Assessment annually to ensure it accurately reflects the needs for its residents. This applies to all residents residing in the facility. The findings include: The facility census dated 6/9/26 shows 77 residents residing in the facility. The Facility's Assessment was last revised and updated 7/31/23. Approximately three years without the assessment being reviewed or revised. On 6/10/26 at 2:00 PM, V3 (ADON) said V1 (Administrator) is responsible for updating and reviewing the facility assessment annually. V3 confirmed the assessment has not been updated or reviewed since 2023. V3 added the facility does not have a policy on Facility Assessment. On 6/10/26 and 6/11/26, V1 was not available at the facility to be interviewed. On 6/15/26 at 12:00 PM, V1 said he thought the facility assessment was reviewed last year.