

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0047241		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/12/2025	
NAME OF PROVIDER OR SUPPLIER CLARIDGE HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 700 JENKISSON , LAKE BLUFF, Illinois, 60044			
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S0000	Initial Comments Investigation of Facility Reported Incident of 09-07-2025/2610524 Compliant Investigation: 2518606/2611205		S0000			09/29/2025	
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.3100d)2) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be		S9999			09/29/2025	

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 provided to each resident to meet the total nursing and personal care needs of the resident. Section 300.3100 General Building Requirements d) Doors and Windows 2) All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required. These Regulations are not met as evidenced by: 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. The 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 7/6/25 showed severe cognitive impairment and the ability to walk independently with staff supervision. R1's elopement risk assessment dated 7/1/25 showed R1 was not physically able to leave the building and was not confused or disoriented (conflicts with the facility assessment).		S9999				

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S9999	Continued from page 2 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 R1 eloped. 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		S9999				

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S9999	Continued from page 3 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 feeding a resident breakfast on Sunday in a second-floor room when she looked out the window and observed R1 outside. V5 said she immediately notified V4 (RN). V5 said R1 appeared confused and was wandering around the parking lot. V5 said the key card for the second-floor elevator hasn't been working for a while. On 9/11/25 at 11:25 AM, V2 (Assistant Director of Nurses) stated she was just arriving to the facility on Sunday when the police were leaving. V2 said she was told R1 had got out and the police eventually located him near the intersection of a large, local hospital. V2 said she did the incident investigation and interviewed R1 with a translator. R1 said he was trying to find his mother. V2 said R1 is on a lot of psychiatric medications and has a pretty low cognitive status. V2 said her investigation results showed R1 opened the elevator and got on it alone. V2 said she was sure he was able to get on it alone. V2 verified the key card was not working and hadn't worked for almost a month. V2 said a front desk person doesn't start until 9 AM each day and the front door is unlocked around 6 or 7 AM daily. On 9/11/25 at 11:45 AM, V6 (Elevator Security Vendor) stated he has worked on the facility's second floor card access system for years. V6 said he was at the facility a few weeks ago and told staff the system "has failed". It is a 30 plus year old system and it can't be patched back together anymore. V6 said the electronic key card system control board can't be repaired anymore. V6 said he repeatedly sent a quote for a new system and never heard anything back until this past Sunday (9/7, day of the elopement). That was when his emails were finally acknowledged, and they agreed to go ahead to fix the system. V6 said right now			S9999			

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S9999	Continued from page 4 the second-floor elevator is a "fail safe" set up which means it will still open when the key card is not working. That prevents anyone from getting trapped in case of an emergency. V6 said right now, anyone can get on or off that elevator. There is no security system in place. V6 said we are still waiting on the parts to be shipped in. The facility provided a quotation invoice dated 8/18/25 from V6's security company. The quote stated, "Replace card access system that controls the elevator buttons on the 2nd floor and the stairwell door on that floor. System has to be designed as "fail safe". Needs to be interfaced with the existing fire alarm system for emergency release." The quote was blank under the client signature date section. The facility provided a receipt dated 9/9/25 (two days after R1 eloped) showing a downpayment for the 2nd floor elevator was processed by V6's security company. On 9/11/25 at 1:00 PM, V7 (Maintenance Staff) stated the second-floor security pad hasn't been working for a couple of weeks now. V7 said an outside company does all the repairs on that. The outside company has been notified, and the part is on order. It won't be here for several more days. On 9/12/25 at 10:57 AM, V9 (local police officer) stated he got a call on 9/7/25 related to a missing elderly person from the subject facility. It was reported the resident had dementia. V9 said he responded to the call along with several colleagues. The DON (V1) said she called us about 10 to 15 minutes after realizing the resident was missing. V9 said they checked the immediate area with trained dogs. V9 said he went inside and asked V1 how did this happen. V1 answered the missing resident resides on the second floor and the security pad system was broke. She was in the process of trying to get it fixed. V9 said R1 was only found after a random passerby saw him walking in the road. She thought he looked confused or lost so she called the local police department and reported it. That police department responded to the area and sent out notice of a missing person too. V9 said that is when we realized that sounded like our guy. V9 said he took R1 back to the subject facility and V1 confirmed his identity. V9 stated there was no one manning the front desk and he could not find any staff when he initially arrived. V9 stated he rode the elevator up to the second floor with V1. At no time did V1 need a key card to operate the elevator up or back down. V9 stated fellow co-workers mentioned later to him that they have responded to calls in the past at the same facility.		S9999				

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S9999	Continued from page 5 Co-workers said they have never needed anything special to go on or off the dementia unit floor. V9 said there are railroad tracks right behind the facility that run all the way parallel to the busy highway, where R1 was found. V9 said they were so worried R1 may be hit by a train that they called the railroad line and confirmed none were scheduled for that day. V9 said the area where R1 eventually was found was by the same tracks. V9 said R1 was found in the road walking the wrong way in traffic. The road is a heavily traveled four lane highway. V9 stated it is the facility's job to keep these people safe and if someone gets out like that, they are not doing their job. The local police department's report dated 9/7/25 and authored by V9 stated R1 was located at 9:35 AM and the exact address of the intersection was provided in the report. The report showed R1 was walking southbound IN the northbound lanes. A google map search from the facility to the intersection showed it was an approximately two-mile walk. On 9/11/25 and 9/12/25, this surveyor was able to freely exit the second-floor dementia unit during the entire survey without using any key card security device. R1's care plan showed a focus area for risk for wandering/elopement due to an elopement event on 9/7/25. The initiation date and interventions were dated 9/8/25. The facility's undated Missing Person/Elopement Policy states: "Safety of all residents is the primary care standard at (subject facility). Impaired judgement, perception, and thought processes of cognitively impaired persons make the residents at a higher risk for elopement into unsupervised or unsafe areas. Precautions, procedures, staff, and visitor education have been put in place to maximize resident safety." (A)		S9999				