

Illinois Department of Public 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 03/19/2026	
NAME OF PROVIDER OR SUPPLIER CLARIDGE HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 700 JENKISSON , LAKE BLUFF, Illinois, 60044			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
S0000	Initial Comments Complaint Investigation: 2613110/2805140 Investigation of Facility Reported Incident of 03-12-2026/2801890			S0000			04/03/2026
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 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 provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents'			S9999			04/03/2026

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 respective resident care plan. 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 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 and 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 and supervision in the sample of 3. 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,			S9999			04/03/2026

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S9999	Continued from page 2 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. 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.			S9999			04/03/2026

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S9999	Continued from page 3 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. (A)	S9999				04/03/2026	