Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001093	A. BUILDING: ______ B. WING ______	04/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT HLTH CR CTR-NORTHBRK	2155 PFINGSTEN ROAD NORTHBROOK, IL 60062

(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) COMPLETE DATE
S9999	Final Observations Statement of Licensure Violations 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. This requirement is NOT MET as evidenced by: Based on observation, interview and record review, the facility failed to maintain a functional East Orchard Unit door alarm to ensure that dementia resident does not leave the secured Alzheimer ' s unit unsupervised and wander into the facility parking lot. This applies to 3 (R9, R10 and R18) of 28 residents in the secured Alzheimer unit identified as wanderer and at risk for elopement. The findings include: On 4/21/15 at 12:00 PM, the East emergency exit door in Alzheimer unit leading to the outdoor parking lot did not produce an alarm when the door was opened to test the alarm function. E4 then walked to the nursing station, examined the alarm settings and switches on the alarm control board, found the East door alarm power switch in the off position, and turned the power switch to the on position. E4 stated the toggle switch, which was turned off when the alarm was believed to be on an tested, provides power to the alarms at the nursing station as well as the alarm box at the exit door. E3 stated the toggle switch must have been turned off by someone and not turned on. The toggle switch is located within	S9999	**Attachment A** **Statement of Licensure Violations**	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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S9999	Continued From page 1	S9999		

cognitively impaired residents ' reach and unprotected from tampering. E4 re-tested the alarm by opening the East door. The alarm at the nurse ' s station sounded, however the alarm located at the East door did not as expected. E4 stated he was unable to explain why the door alarm was not functioning properly.
At 8:20 AM on 4/22/15, Z1 (Electric Contractor) stated the door alarm box malfunctioned and the entire alarm box needed replacing. Per the 4/22/15 electric contractor report, Z1 removed the old unit and install new alarm. At 8:45 AM, E4 demonstrated the replacement alarm box was functional and both alarms sounded when the emergency exit door opened as intended. On 4/21/15 E1 stated the facility had no policy or procedure in place to check the functional status of any exit door alarms in the facility or those on the secure Alzheimer ' s Unit.
On 4/22/14, E10 (Registered Nurse) identified three residents (R9, R10 and R18) in the secured Alzheimer ' s unit, as residents identified as wanderers and at risk for elopement.
On 4/22/15, R18 ' s face sheet showed a diagnosis of Alzheimer ' s disease, dementia with behavior disturbances, and senile psychosis. On 4/11/15 the Quarterly Nursing Assessment and Documentation (QNAD) showed R18 ' s safety should be monitored by staff, R18 " will occasionally wheel herself down the halls of Orchard Court and has opened the inside alarm door several times, " and " short term memory deficit and moderately impaired decision making, and score on Brief Interview for Mental Status (BIMS) assessment dated 4/6/15 showed severe cognitive impairment. The care plan showed that R18 attempted to leave the unit, enter potentially unsafe areas and opened exit door.
R10 ' s face sheet dated 4/22/15 showed a diagnosis of Alzheimer ' s disease, and anxiety

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S9999	Continued From page 2 state. R10 ' s care plan dated 4/22/15 showed R10 is to " continue with placement in secure unit - Orchard Court. Ensure all door alarms/locks are armed to reduce the risk of R10 leaving secure area. " On 4/2/15, R10 ' s BIMS assessment showed severe cognitive impairment. R9 ' s face sheet dated 4/22/15 showed diagnosis of Alzheimer ' s disease, dementia without behavior disturbances as well as dementia with behavior disturbances, and senile psychosis. R9 ' s care plan dated 3/5/15 showed R9 " has exhibited wandering behavior. He is also an elopement risk as he has pushed through alarmed doors a few times. " On 3/5/15 R9 ' s care plan approach showed, " Place in memory support unit-Orchard Court. Ensure all door alarms/locks are armed to reduce the risk of R9 leaving secure area. " ADCD elopement assessment dated 11/7/14 showed R9 at high risk of elopement. On 2/16/15 R9 ' s BIMS assessment showed severe cognitive impairment. (B)	S9999		