STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146085	A. BUILDING _____ B. WING _____	C 02/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A MERKLE C KNIPPRATH N H	1190 E 2900 NORTH ROAD CLIFTON, IL 60927

(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
F 000	INITIAL COMMENTS	F 000		
F 323 SS=D	Incident Report Investigation of 1-18-16/IL83137 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to implement preventative fall measures for one of three residents (R1) reviewed for falls in a sample of three. Findings include: The Fall Care Plan dated 10/1/15 documents R1 with a history of falls and motion alarm in place at all times. The Initial/Final facility report of R1's fall incident dated 1/19/16 documents, "On 1/18/16 at 6:20am, staff called into (R1's) room via roommate (R3), who heard a sound and saw (R1) on the floor....(R1) had a motion alarm in place to her mattress that was not sounding....X-Ray report (1/18/16) revealed demineralization with non-displaced sacral fractures, age undetermined." On 2/3/16 at 7:45am, R3 stated R1 fell recently	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 1	F 323		

after getting out of bed without asking for assistance. R3 stated an alarm was not sounding at the time of R1's fall.

R3's Minimum Data Set dated 1/26/16 documents R3 as moderately cognitively impaired. The facility list of interviewable residents dated 2/3/16 documents R3 as interviewable and R1 as not interviewable.

On 2/3/15 at 9:00am, E3 (Nurse) stated on 1/18/16 R3 came out of the bedroom to report R1 had fallen. E3 stated E3 went immediately into the bedroom and was the first to respond. E3 stated R1 was sitting on the floor, holding onto a siderail on the bed with one hand and facing the sink area of the room. E3 stated, "I don't recall the alarm sounding." E3 also stated a motion alarm was not underneath R1 at the time of the fall.

On 2/3/16 at 11:00am, E2 (Assistant Director of Nursing) stated R1 is supposed to have a motion alarm while in bed at the time of the fall on 1/18/16.

The facility policy dated 11/23/15 documents appropriate interventions will be put into place to prevent the risk of falls.