STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003388	A. BUILDING: _____ B. WING _____	C 04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP MANOR	1209 21ST AVENUE ROCK ISLAND, IL 61201

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S 000	Initial Comments Investigation of Facility Reported Incident of March 26, 2025/IL189181	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b)4)5) 300.1210d)6 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. 4) All nursing personnel shall assist and encourage residents so that a resident's abilities	S9999		

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S9999	Continued From page 1	S9999		

in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure a resident was safely positioned in bed for 1 of 3 residents (R2) reviewed for safety in the sample of 5. This failure resulted in R2 falling from her bed and sustaining a laceration requiring staples.

The findings include:

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R2's physician visit form documents she was admitted to the facility on 7/10/24 with multiple diagnoses including vascular dementia, and history of falling.

R2's quarterly resident assessment and care screening of 2/17/25 documents her to have severe cognitive impairment. Her mobility assessment shows she requires substantial/maximal assistance with rolling right to left. Meaning the helper provides more than half of the effort to perform the task. The 2/17/25 care plan for hospice services notes R2 requires extensive to dependent assistance with 1 staff for all cares and uses a mechanical lift for transfers.

The facility incident report of 3/26/25 documents R2 had a fall at 4:50 AM in her bedroom by the bedside. The description of the incident was staff preparing resident to get up and resident rolled out of the bed and fell on the floor with head injury and bleeding. Sent to the ER (emergency room) for further evaluation.

On 4/9/25 at 10:22 AM, V13 (Certified Nursing Assistant/CNA) said on the morning of 3/26/25, she was getting R2 ready to get out of bed. When she does care for any resident, she has the bed in the high position, so it is easier on her back, and she had R2's bed in the high position, probably to her waist or higher. V13 said during cares, R2 can either be stiff and difficult to move, or she is wiggly. V13 said on that morning, after she had R2 dressed, she rolled her towards the wall, and placed the mechanical lift sling under her and needed to pull it through. V13 said she moved R2's bed out from the wall, and standing between the wall and the bed, she rolled R2 towards the other side, and R2 began moving her legs and fell off the side of the bed. She said the

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bed had no side rails, so R2 just fell to the floor, landing on the concrete floor on her back. V13 said there was nothing she could do to stop it because she was on the opposite side of the bed. V13 said there was immediately blood present, and she notified the nurse.

The ED (emergency department) report for 3/26/25 documents the reason for the visit was a laceration to the scalp. The physical exam shows a 1 cm (centimeter) laceration to the occipital (back of the head) area. The laceration repair included the placement of 4 staples.

On 4/9/25 at 11:00 AM, R2 said she had no pain and forgot she had staples to her head. She was sitting up in her reclining wheelchair visiting with her sister. She had no bruising or signs of any further injury.

On 4/9/25 at 2:30 PM, V2 (Director of Nursing) said the incident was reported to her, and she spoke with V13 about the details. She said V13 was by herself when providing care for R2, when she went to the opposite side of the bed, leaving R2 facing the open side of the bed. V13 reported to her, she was placing the mechanical lift sling when R2 put her foot out over the edge of the bed and fell because there was no one there to catch her. V2 said none of the beds have side rails, so there was nothing to catch R2. V2 said she did not know how high the bed was raised at the time of the fall; a lot of staff raise the beds for better body mechanics. She said maybe it was not safe to have 1 person providing care. And R2's fall mat should have been in place.

On 4/10/25 at 8:20 AM, V12 (Licensed Practical Nurse/LPN) said on the morning of 3/26/25, V13 had poked her head out of R2's room and notified

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S9999	Continued From page 4 him of the fall. Upon arrival to R2's room he found her lying on the floor, face up with blood coming from her head. V12 said he immediately called 911 to have her sent out to the emergency room. He said R2 was on the concrete floor and the fall mat was off to the side. He observed R2's bed to be in a higher position, probably about 3 feet up in the air. The facility's 2018 falls and fall risk management defines a fall as unintentionally coming to rest on the ground, floor, or other lower level. Fall risk factors 1. Environmental factors that contribute to the risk of falls include c. incorrect bed height. 2. Resident conditions that may contribute to the risk of falls include: c. delirium and other cognitive impairment. "B"	S9999		