STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0024760	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/12/2025

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

(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 Investigation of Facility Reported Incident of September 2, 2025/2610671 Complaint Investigation: 2528543/2611061	S0000		09/25/2025
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b)4)5) 300.1210d)3)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	S9999		09/25/2025

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

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S9999	Continued from page 1 residents so that a resident's abilities 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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 interview and record review, the facility failed to ensure 1 of 3 residents (R1) was transferred safely. This failure resulted in R1 falling and fracturing her right femur. The findings include: On 9/12/25 at 12:45 PM, V9 (Certified Nursing Assistant/CNA) said she was R1's CNA when R1 fell on the morning of 9/2/25. V9 said a couple days prior when she was caring for R1, R1 complained of arm pain and wanted to get up in her chair because of her arm pain.	S9999		

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S9999	Continued from page 2 The morning of 9/2/25, R1 complained of right arm pain again and asked V9 to put her in her chair (recliner). V9 said she changed and dressed R1 with pants, shoes, socks, and a clean brief, then she helped position R1 on the side of her bed. V9 said she put the transfer aid device/lift machine, up against the bed and assisted R1 to put her feet on the platform, then R1 grabbed the bar and V9 used the back of R1's pants to help her stand up. V9 said the lift machine was so close to the bed, she couldn't get the paddles down, so she took the brakes off and pulled the lift machine out away from the bed. V9 said before she could get the paddles down, R1 said "I'm falling" and let go of the bar. V9 said she tried to grab the back of R1's pants/brief to somewhat catch her, so she didn't have a direct hit on the floor, but R1 ended up falling on the floor into a sitting position with her legs straight out. V9 said the machine got pushed out in front of R1. V9 said she went and told V8 (Licensed Practical Nurse/LPN). V9 said R1 was screaming at them and yelling that her leg hurt, that they broke her leg, and they dropped her on the ground. V9 said she felt that something was wrong, because R1 doesn't really yell at her like that. V9 said she should have used a gait belt when transferring R1. V9 said she was told R1 fractured her leg. V9 said she probably should have automatically had a gait belt on R1 when using the machine so she could have held it and prevented R1 from falling. V9 said she wasn't thinking there was going to be issues with the transfer, so she didn't use one. On 9/12/25 at 12:23 PM, V10 (Certified Nursing Assistant/CNA) said V9 came and got him because she needed his help because R1 was on the floor outside of her bathroom. V10 said V9 told him when she was putting the paddles (of the machine) in position, R1 sat back, and the paddles were not in place and R1 fell onto the floor. V10 said R1 did not have a gait belt on when he arrived to assist V9 with R1. V10 said you should always use a gait belt when transferring a resident, especially when using a device where the resident needs to pull themselves up. V10 said if a resident was having arm pain while preparing to use the lift machine to transfer them, he would stop the process. V10 said they are empowered to use their own judgement and could get a total lift device instead. V10 said R1 is a little feisty and unpredictable and he feels like there should be two persons to transfer R1 specifically. V10 said she can be rambunctious at times, and she doesn't want to help much at times. V10 said when using the machine, you scooch the machine right up to the resident, put their feet on the platform, lock the brakes, and the resident reaches for the bar. The staff member uses the gait belt to assist the resident to	S9999		

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S9999	Continued from page 3 standing. Once they are standing securely, staff gets the paddles into position as quickly and as smartly as possible, then instructs the resident to lean back on their bottom. On 9/12/25 at 2:10 PM, V8 (LPN) said he was R1's nurse when she fell. V8 said V9 came to him and needed help with R1. V8 said when he got to R1's room, R1 was tangled in the lift machine in front of her bathroom door. V8 said she was dangling half in and half out of the lift. R1's feet were off the platform, her arms were draped over the grab bar, and one paddle was in the up position and the other was in the down position. V8 said R1 was hollering and screaming; she was hanging from the lift. V8 said R1 couldn't move because she was basically wedged in by the paddle. V8 said they moved the paddle and lowered R1 down to the floor. V8 said when using the machine, they are supposed to lock the brakes, use a gait belt to help the resident so they can grab the bar, and then engage the paddles so they can lean back/sit on them. V8 said R1 complained of right lower extremity pain, so he requested an Xray. V8 said R1 eventually went to the hospital and was diagnosed with a displaced fracture. On 9/12/25 at 11:35 AM, V3 (Director of Rehab/Physical Therapist) said when using a lift machine for a resident transfer, the machine is positioned directly in front of the resident, their feet go onto the platform, the machine is locked so it doesn't roll forward, then the resident reaches out and pulls themself to a standing position and the paddles are rotated down to form a seat and the resident's knee/shins saddle into the knee/shin pads and they sit onto the seat formed by the paddles. V3 said the machine can be used with one staff person with the resident wearing a gait belt. V3 said the resident has to have the core strength to pull themself up into a standing position. On 9/12/25 at 1:42 PM, V2 (Director of Nursing/DON) said R1 had been a transfer via the lift machine. V2 said R1 was getting weaker and either fell, or almost fell, so they changed her to a (name of a different kind of lift machine). V2 said R1 hated that lift because it was uncomfortable, so they went back to a (name of previous lift machine). V2 said R1 has not been ambulatory for at least two years. V2 said when using the lift machine, it is required to use a gait belt on the resident. R1's Detailed Summary (undated) provided by the facility shows R1's diagnoses include, but are not limited to, osteoarthritis, arthritis, tremor,	S9999		

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S9999	Continued from page 4 unsteadiness on feet, need for assistance with personal care, muscle weakness (generalized), difficulty in walking, history of falling, and weakness. R1's Interdisciplinary Notes dated 9/2/25 at 6:33 AM show R1 was on the floor this morning from a transfer with the (name of lift machine). R1 did not have seat pads in place and was not standing up well, and she let go of the bar and went down to the floor. R1's legs caught and were tangled on the (name of lift machine). R1 was screaming about her right leg being broken. R1's current care plan provided by the facility shows R1 has a potential to fall due to impaired balance. R1 is unable to ambulate and has a history of falls. R1 has severely impaired cognition. R1 can become agitated with staff, combative, and verbally aggressive and resistive to cares. R1 requires extensive staff assistance for transfers. R1's Minimum Data Set dated 8/10/25 shows R1 has severely impaired cognition and requires substantial/maximal assistance (helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with sit to stand, chair/bed-to chair transfer, roll left and right, sit to lying, and lying to sitting on side of bed. R1's results of her right femur Xray obtained on 9/2/25 show the Xray was taken due to right leg pain after a fall. The Impression shows a displaced periprosthetic fracture of the distal right femur. The facility's (name of lift) Transfer Aid Policy/Procedure (undated) shows the steps for use are to raise the two split seat units so they are parallel to the side of the device, have the patient positioned at the edge of the surface to be transferred from, move the (name of lift) in front of the patient and position the patient so their feet are firmly on the platform and their knees and shins are in contact with the two cupped kneepads. LOCK the casters, have the patient grasp the cross bar closest to them and, using their own strength, pull themselves up into a standing position securely on the base platform. Lower both of the split seat units into position to form a complete seat, then have the patient lower themselves down onto the seat while keeping their knees and shins in the kneepads while continuing to hold the cross bar with both hands. Then UNLOCK the casters and move the device to the new surface. "B"	S9999		