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 12/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP MANOR	1209 21ST AVENUE ROCK ISLAND, IL 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) COMPLETE DATE
S 000	Initial Comments Investigation of Facility Reported Incident of November 20, 2022/IL153763.	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 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. d) Pursuant to subsection (a), general nursing	S9999		

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S9999	Continued From page 1 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 interventions were implemented for a resident (R1) assessed as high risk for wandering, failed to provide supervision when a wandering, cognitively impaired resident (R1) exited the hallway via a wheelchair into an unattended, unalarmed stairwell and failed to ensure that the Short Stay Rehab 1 Main door was alarmed to notify staff of an unsupervised resident in a stairwell. These failures resulted in R1 not being adequately supervised and exiting the unattended, unalarmed door, into the facility stairwell on 11/20/22 around 5:30 P.M. R1 suffered a contusion/abrasion to the right temporal region and mid forehead, a 5.5 centimeter (cm) laceration to the right posterior occipital region, bruising to the right dorsal side of the middle and index fingers, and bruising to the right forearm. R1 is one of seven residents (R4, R5, R6, R7, R8, R9), reviewed for falls and wandering behavior, in a sample of 9. FINDINGS INCLUDE: The facility policy, Wandering and Elopements, dated (revised March 2019) documents, "The	S9999		

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S9999	Continued From page 2 facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents." R1's Facility Incident Report, dated 11/20/22 and signed by V5 (Licensed Practical Nurse/LPN) documents, "(R1) was found pounding on basement door, yelling for help. V3 (Housekeeper) got V6 (Certified Nursing Assistant/CNA). V6 stayed with (R1) while V3 got V5. (R1's) wheelchair found after first flight of stairs. Laceration noted to back of head. Bruising on temple and right hand. Sent to ER (Emergency Room)." R1's hospital Emergency Room Report, dated 11/20/22 at 6:18 P.M., "(R1) is a 91 year old female presenting to the ED (Emergency Department) by ambulance for a laceration on the back of her head after falling today. (R1) is coming from (facility). (R1) does not remember falling and does not know how long she was on the ground. (R1) also has bruising to her right wrist and fingers, left knee pain and neck pain. Examination: Tenderness to posterior skull. Contusion/abrasion to right temporal region and mid forehead. Laceration to right posterior occipital region, Bruising to right dorsal side of middle and index fingers. Bruising to right forearm. Procedure: Laceration repair to 5.5 CM (Centimeter), right posterior occipital region. Clinical Impression: Facial contusion; Traumatic injury of head; Complex laceration of scalp." R1's facility Face Sheet (Detailed Summary) documents that R1 was admitted to the facility on 07/06/2019 with the following diagnoses: Dementia, Macular Degeneration, Osteoarthritis, Unsteadiness on Feet and Generalized Muscle	S9999		

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S9999	Continued From page 3 Weakness. R1's current Minimum Data Set Assessment, dated 9/12/22 documents R1's vision (Section B: Hearing, Speech and Vision) as "Moderately impaired - limited vision." This same form documents R1's cognition (Section C: Cognitive Status) as "Three : Fifteen - cognitively impaired." This document also includes R1's Functional Status (Section G: Walking) as "Requires assistance from staff." R1's Fall Risk Assessment, dated 11/20/22 documents that R1 is at high risk for falls (Score: 22, greater than 10 equals high risk). R1's Elopement Risk Assessment, dated 9/12/22 documents that R1 is at high risk for elopement (Score 34, greater than 12 equals high risk). R1's current Care Plan, dated 9/12/22 includes the following problem Area: (R1) has a tenancy to wander up and down the halls and will forget where her room is or what she is doing. (R1) will often tell staff that she lives right down the street and will walk home. (R1) wears a (name of alarm system) for her safety. (R1) has been exit seeking during this assessment period. Also included are the following Approaches: Please intervene as needed to ensure my safety and the safety of others; Reorient resident as needed; Redirect (R1) away from any exits; Modify (R1)'s environment, situations or treatments to minimize (R1)'s episodes; Redirect (R1) to more appropriate activities; Ask (R1) if she would like a cup of coffee." On 12/5/22 at 8:30 A.M., A tour of the facility Short Stay Rehab Unit 1 door with V4 (Assistant Director of Nurses) shows R1 entered the	S9999		

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S9999	Continued From page 4 unlocked stair-well from the first floor, Main facility Short Stay/Rehab Unit 1 door, unattended. This stairwell then leads to another unlocked door with an approximate 2-foot platform then a flight of 5 steps down, a landing platform with a turn to the left and then 11 steps down, another left turn with 3 steps down, another left turn and ends at the facility basement door. At this time, the doors remain unlocked and unattended. A second exit door, on the facility first floor is locked and alarmed with a (alarm system) to notify staff if a facility-identified, cognitively impaired, wandering resident attempts to open the door, unattended. A tour of the facility second floor shows both exit doors locked and alarmed with a (alarm system). On 12/5/22 at 8:27 A.M., R1 was seated in a wheelchair at a table by herself in the facility Bistro finishing the morning meal. At that time, R1 wheeled herself away from the table, out the door and into the hallway. R1 propelled her wheelchair past her room and down the hall. At that time, a staff member stopped R1 and the staff member wheeled R1 into R1's room and placed her in bed. On 12/5/22 at 12:23 P.M., R1 was seated in a wheelchair, propelling herself from the dining room. R1 turned her wheelchair, away from her room, towards the Short Stay Rehab 1 door. At that time, a facility staff member stopped R1 and wheeled R1 into R1's room and placed her in bed. On 12/5/22 at 8:47 A.M., V3 (Housekeeper) stated, "I have been employed here for almost 41 years, as a housekeeper. I was working the evening that (R1) fell down the stairs. It was around 5:30 P.M. I was in the basement, and I heard knocking on the door. I looked through the	S9999		

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S9999	Continued From page 5	S9999		

glass and could see (R1) leaning against the door, with blood coming from the top of her head. I couldn't get her to step back from the door, so I could open it. I ran to the basement elevator and went to the first floor. I yelled at V6 (CNA) to get V5 (LPN). I had to enter the stairwell to get to (R1). The Short Stay Rehab 1 door was unlocked like it usually is. I found (R1's) wheelchair turned over at the bottom of the next flight of stairs. There was also one shoe and a large pool of blood. When I got to the bottom of the stairwell, outside of the basement door, I found (R1). (R1) was bleeding heavily from her head. A couple of nurses and other staff came to help her. I left then, so they could help her. Those doors have never been locked or even alarmed. I don't know why. The second floor (Rehab 2 Unit) has two doors that are locked and have alarms on them."

On 12/5/22 at 10:05 A.M., V5 (LPN) stated, "I was (R1's) nurse the night she fell down the stairs. It was (11/20/22) around 5:30 , when V7 (LPN) came running by me and said that (R1) was found at the bottom of the stairs. We went through the door on Rehab 1, then through the next door, where there are just a few steps. That's where we found her wheelchair and a big puddle of blood. None of the doors are locked or alarmed there. When we got to the bottom, at the basement door, that's where we found (R1). (R1) was bleeding from her head pretty badly. We got (R1) in (R1's) wheelchair and took her up the elevator to the nurse's station and called the ambulance. (R1) was pretty restless all afternoon, before she fell. (R1) was up in her wheelchair, just wandering around. (R1) had eaten her supper around 4:00 (PM) or so. (R1) has fallen a number of times. I'm not sure if any other resident has fallen down the stairs or not. They could have, those doors are unlocked and there isn't an

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S9999	Continued From page 6 alarm on them." On 12/5/22 at 1:11 P.M., V1 (Administrator) stated, "After (R1) fell down the stairs through that door, I was shocked to find out there isn't an alarm on that door. That door (Short Stay Rehab 1) has never been alarmed. I was told that back in 2010, a State Architect said we couldn't alarm it with a 15-second delayed egress alarm. Basically, an alarm for elopement. I have the city Fire Marshall coming sometime later this week to look at it. No, there isn't currently a door alarm without a 15 second delay, on that door, to alert staff when the door is opened. That door is not an exit door, it only goes to the basement or to the second floor." On 12/5/22 at 2:132 P.M., V6 (CNA) stated, "I was working the evening that (R1) fell down the stairs. She was in my group (assignment). I came on (shift) at 2:00 PM and (R1) was very agitated and irritable, (R1's) normal self. I'm not sure what (R1's) care plan says to do when (R1) acts like that. I just left (R1) alone. The last I saw (R1), before the accident, was in the dining room. I was in the Café (independent eating dining room) and I saw (R1) in there, that would have been after 4:00 o'clock. That's when they start serving supper. A little while later, when I finished in the Café, I went over to the Sunshine Room (dependent eating dining room) and helped feed (residents that require assistance)." "A"	S9999		