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
	IL6003388	A. BUILDING: ______ B. WING ______	07/24/2024

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FRIENDSHIP MANOR	**1209 21ST AVENUE ROCK ISLAND, IL 61201**

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S 000	Initial Comments Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and	S9999		

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provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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 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

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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 follow the facility's fall program and provide supervision for three (R15, R18, and R60) of six residents reviewed for falls in the sample of 28. These failures resulted in: R15's hospitalization resulting from nasal fractures; R18's hospitalization resulting from a tibial fracture; and R60's hospitalizations resulting from a right hip fracture and then left hip fracture.

Findings include:

The facility's undated Managing Falls and Fall Risk policy and procedure, documents: "Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling." "Resident-Centered Approaches to Managing Falls and Fall Risk: 1. The staff will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls... 5. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. 6. If underlying causes cannot be readily identified or corrected, staff will try various interventions,

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based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable." "Monitoring Subsequent Falls and Fall Risk: 1. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling... 3. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions."

The Falling Star Program sign documents "A falling star is placed on the doorway and w/c (wheelchair) if resident meets the following criteria: 1) Has had more than 2 or more falls in the past 3 months. Follow these Falling Star Guidelines: 1) Do Not leave unattended in the bathroom or room (if up in w/c), 2) Refer to restorative, 3) Attempt to keep in highly visible area when up in w/c."

The facility's Falling Star Program, dated 6/1/2023, documents "Upon admission, the nursing staff will review a resident's record for a history of falls, especially falls in the last 90 days and recurrent or periodic bouts of falling over time." "The fall risk assessment will be used to implement the Falling Star program to alert staff that a resident has a higher risk for falling. The Falling Star symbol will be placed on the resident's name tag and wheelchair if applicable. The Falling Star program would be implemented if the resident triggers high risk for falls per the fall assessment." The "interventions for the Falling Star program should be resident specific and follow the care plan."

On 7/23/24 at 3:39 pm, V3 (Chief Nursing Director) and V2 (Director of Nursing/DON)

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stated they do all the reportable fall incidents together to determine route cause and make sure there are interventions in place.

On 7/24/24 at 10:55 am, V3 (Chief Nursing Director) confirmed the Falling Star Program posted signage was for residents who are at a high risk for falls, depends on the resident, and resident specific. V3 confirmed these residents should not be left unsupervised.

1. R15's Face Sheet includes the following diagnoses for R15 as: Alzheimer's Disease, Unspecified Dementia, Generalized Anxiety Disorder, Major Depressive Disorder, Cognitive Communication Deficit, Lack of Coordination, and Need for Assistance with Personal Care.

The Annual MDS (Minimum Data Set) Assessment for R15, dated 6/20/24, documents R15 with severe cognitive impairment and requires substantial to maximal assistance with toileting hygiene, bathing, lower body dressing, personal hygiene. R15 requires partial to moderate assistance with oral hygiene, upper body dressing and is dependent for putting on/removing footwear. R15 requires substantial to maximal assistance with all mobility.

The Fall Risk Assessment for R15, dated 3/25/24 and 6/20/24, document a fall risk score of 13 and 12 respectively and documents "A score of 10 or more indicates High Risk for Falls."

The current Care Plan for R15, documents R15 has potential to fall due to impaired balance, requires one-to-one assist to transfer with a non-mechanical lift, and does not call for assist consistently. R15 requires extensive assistance from staff with bed mobility, dressing, bathing,

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hygiene, transfers, and toileting. This same Care plan documents R15 had prior falls on 9/25/23, 12/20/23, and 2/28/24. Interventions include to assist with reposition every two hours and as needed. An intervention was added after R15's 9/25/23 fall to not be left unattended in her room while sitting in her wheelchair.

The Progress Note for R15, dated 7/18/24 at 5:54 pm, documents "(R15) unwitnessed fall from w/c to floor in hallway. Nurse sitting at nurse's station and heard. (R15) observed lying on right side, right arm under body, (R15) facing the floor. (R15) bleeding from nose and above left eye. Cool compress applied to side of nose and left eye." R15 sent to the local hospital for evaluation and treatment.

The Progress Note for R15, dated 7/18/24 at 9:28 pm, documents R15 returned from local hospital with fractured nose and to apply ice and elevate head of bed for comfort. Hospice service was notified, and new order received for safety mats at bedside. "Discoloration right eye and nose and bruise to right elbow."

The Incident Report for R15, dated 7/18/24 at 5:30 pm, R15 had unwitnessed fall in the hallway from her wheelchair to the floor resulting in bruising with bleeding from contusion. R15 has a history of multiple falls, R15 was leaning forward in her wheelchair and fell out. R15 complained of pain and was sent to the local hospital for evaluation.

The Hospital Discharge paperwork, dated 7/18/24, includes a Maxillofacial (face and jawbones) CT (Computed Tomography), dated 7/18/24 that documents findings as: "Mildly displaced left greater than right nasal bone

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fracture, slightly deviated to the left. Overlying nasal bridge swelling. Right preseptal periorbital superior orbital rim contusion. There is minimal fluid stranding left ethmoid air cells." Impression: "Right superior periorbital soft tissue preseptal contusion changes. Suspect nondisplaced bilateral nasal bone fractures."

On 7/21/24 at 9:57 am, R15 was sitting in recliner lounge chair with her eyes closed. Yellow and green fading discoloration was noted surrounding R15's bilateral eyes and to bridge of R15's nose. R15's wheelchair was across the room out of R15's reach with a Falling Star sticker attached to the back of her wheelchair and name plate on doorway, a non-mechanical lift was in R15's bathroom and floor fall mats were in an upright position leaning against the wall.

On 07/23/24 at 10:55 AM, R15 was sitting on the toilet in her bathroom with a non-mechanical lift placed in front of her and there were no staff present. At 10:57 AM, V8 (Certified Nursing Assistant/CNA) entered R15's bedroom, walked into R15's bathroom, assisted R15 off the toilet with the non-mechanical lift, assisted R15 to sit in the wheelchair, and pushed R15 out of the bedroom into the hallway.

On 7/23/24 at 11:04 AM, V8 (CNA) stated R15 does not generally get up by herself.

On 7/24/24 at 10:45 AM, R15's bathroom call light illuminated outside of R15's bedroom. Entered R15's bedroom with V3 (Chief Nursing Director) and observed R15 sitting on the toilet in the bathroom, a non-mechanical lift in front of her, and no staff present. V3 assisted R15 off the toilet with the non-mechanical lift and assisted R15 to sit in the wheelchair. A Falling Star sticker

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2. R60's Face Sheet includes the following diagnoses: Dementia, Cognitive Communication Deficit, Fracture of Left Femur, Fracture of Right Femur, Fracture around Internal Prosthetic Hip Joint, Unsteadiness on Feet, and Need for Assistance with Personal Care.

The Admission MDS (Minimum Data Set) Assessment for R60, dated 2/4/24, documents R60 with severe cognitive impairment with no functional limitations in range of motion. R60 requires partial to moderate assistance of staff for all activities of daily living, dependent for lower body dressing and putting on footwear, and requires partial to moderate assistance for all mobility. R60 has a history of falls within the last 2 to 6 months prior to admission and one fall without injury since admission and was not receiving skilled therapy services.

The Quarterly MDS Assessment for R60, dated 5/26/24, documents R60 with "moderately impaired" cognition, functional limitation in range of motion to one lower extremity, now requiring substantial to maximal assistance for toileting hygiene, bathing, lower body dressing, footwear, personal hygiene. R60 now requires substantial to maximal assistance with all mobility. R60 with falls in last month, falls in last 2 to 6 months, fracture related to falls, and receiving skilled therapy services.

The Fall Risk Assessments for R60, dated 2/4/24, 3/6/24, 4/24/24, and 5/24/24 document R60 with fall risk scores greater than 10. These forms also document "A score of 10 or more indicates High Risk for Falls."

The current Care Plan for R60, documents R60

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with dementia, confusion, and severe impaired cognition requiring cues and supervision for safe decision making, monitor positioning while in wheelchair and assist as needed. "Needs reminders of using the call light. Fall risk-staff to monitor. Will try to self-transfer at times, has a hx (history) of falls and has poor safety awareness." R60 requires one-to-one assist to stand and walk short distances, and history of self-transfers. R60 has had five unwitnessed falls and two witnessed falls between 2/21/24 through 5/16/24 with unwitnessed fall on 4/20/24 resulting in a right hip fracture and 5/16/24 unwitnessed fall resulting in a left hip fracture. Interventions include Offer bed or recliner after meals; Toilet prior to putting in recliner or offered to stay up; Monitor positioning when in wheelchair and assist as needed.

The Incident Report and Fall Investigation for R60, dated 2/21/24 at 6:30 pm, documents R60 had an unwitnessed fall in her room trying transfer from her wheelchair to her bed, and doesn't remember to use her call light for assistance. The interventions were to ask R60 if she wanted to sit in her recliner or go to bed after meals and R60 was educated to use her call light and for staff to check on R60.

The Incident Report and Fall Investigation for R60, dated 3/2/24 at 9:00 am, documents R60 had unwitnessed fall in her room from her recliner and was found scooting on her buttocks from her room into the hallway "looking for help." The reports document R60 had taken off her slippers, does not use the call light, is unaware of her limitations, requires one-to-one assist to stand. The intervention listed was for staff to ensure R60 is toiled prior to placing in recliner or wheelchair.

The Incident Report and Fall Investigation for

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R60, dated 3/19/24 at 6:35 pm, documents R60 had a witnessed fall in the Activity Center during Bingo, was moving "back and forth" in her wheelchair, and slid out onto the floor on her buttocks. The investigation documents R60 has a history of falls, does not use her call light, requires one-to-one assist for transfers and ambulation. "Dementia is main factor related to this fall, as well as her previous level of independence." The intervention listed is for staff to monitor R60's positioning when up and to assist as needed.

The Incident Report and Fall Investigation for R60, dated 4/20/24 at 10:10 pm, documents R60 had an unwitnessed fall in her room from bed and found on the floor next to her bathroom during the CNA care rounds, was sent to the local hospital and diagnosed with a right hip fracture requiring surgical repair. This investigation documents R60 is non-verbal, and grimacing in pain when attempts to move right hip and leg, sent to the local hospital, diagnosed with a right hip fracture requiring surgical repair. The immediate intervention listed was for bed to be in the lowest position.

The Incident Report and Fall Investigation for R60, dated 5/12/24 at 1:00 pm, documents R60 had an unwitnessed fall from her wheelchair in front of the Nurse's Station and was found sitting on the floor in front of her wheelchair. R60 was trying to get out of the wheelchair. This investigation documents R60 does not ask for assist and requires one-to-one assist with transfers and ambulation. V12 and V14 CNAs were in other resident rooms assisting and V15 RN (Registered Nurse) was downstairs in another part of the facility, indicating R60 was left unsupervised. Intervention listed was to lay R60

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down after lunch and staff were educated "Do Not leave (R60) alone."

The Incident Report and Fall Investigation for R60, dated 5/14/24 at 8:00 am, documents R60 had witnessed fall during therapy services, became weak and shaky, and was lowered to the floor. The intervention listed was to "work slowly and monitor" R60 and for blood work review.

The Incident Report and Fall Investigation for R60, dated 5/16/24 at 6:15 pm, documents R60 had an unwitnessed fall in the hallway, self-transferred from her wheelchair, walked to the nurse's medication cart, "picked up the pill crusher mechanism, which is heavy" and fell to her left side. R60 was sent to the local hospital and diagnosed with a left hip fracture requiring surgical repair. This investigation documents R60 is currently receiving therapy for her right hip fracture, "is unsafe to be up without one-to-one assist," and will self-transfer without asking for assist. R60's room was moved this day closer to nurse's station. This investigation also documents V14 (CNA) had taken meal trays downstairs, V16 (CNA) was in another resident room assisting, and V17 (Licensed Practical Nurse/LPN) was downstairs in another part of the facility, indicating that R60 was left unsupervised.

On 7/21/24 at 9:00 AM R60's doorway held a name plate with a Falling Star sticker and fall mats were upright resting against the wall. R60 was not in her room at this time.

On 7/21/24 at 10:00 AM, and 7/22/24 at 3:00 pm, R60 was sitting in a wheelchair across from the nurse's station with a Falling Star attached to the back of R60's wheelchair.

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On 7/24/24 at 10:44 AM, R60 was sitting in a wheelchair across from the nurse's station with no staff supervising.

On 7/24/24 at 10:59 AM, V12 (CNA) stated the stars on the doors are for residents who are at risk for falling. They should not be left in the bathroom by themselves. V12 stated "R60 will try to get up by herself at times, and I would not leave her in the bathroom by herself. We try to keep her near the nurse's station so we can keep an eye on her."

On 7/23/24 at 3:39 pm, V3 (Chief Nursing Director) and V2 (DON) confirmed R60 had an unwitnessed fall in her bedroom, by her bathroom, went out to the local hospital and received surgical repair of her right hip on 4/20/24. V3 stated the Intervention for R60's fall was not to leave her in her room when she is up in a wheelchair. V3 stated R60 was previously on the memory care unit prior to coming to the rehab floor where she was with her husband and was able to be up and about independently. R60 was not used to asking for help and is confused. We watched R60's fall on 5/16/24 on the camera and R60 just got up, walked to the medication cart, picked up the pill crusher and fell over and not sure what you mean by root cause of the fall. R60 has Dementia, is confused, and a high risk for falls. V3 and V2 stated they are unsure of fall interventions or route cause for R60's fall on 5/16/24. V3 stated R60 doesn't know what is going on and doesn't know why she fell. V3 stated the facility doesn't do one-on-one monitoring, the CNAs have to answer call lights, and the nurse was passing medications when R60 fell on 5/16/24. V3 stated "We always have enough staff on that floor."

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 ______	07/24/2024

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
S9999	Continued From page 13	S9999		

The current Care Plan for R60 does not reflect R60's individualized specific needs related to her previous falls. There is no documented evaluation for the various interventions based on R60's assessment, nature and category of her falls, and no monitoring or response to implemented failed or successful interventions, resulting in continued falls for R60.

3. The Admission MDS (Minimum Data Set) dated 6/27/24 documents R18 is cognitively intact, upper body dressing at partial/moderate assistance, lower body dressing at substantial/maximal assistance, and putting on/taking off footwear at dependent.

The current Fall Care Plan for R18 documents R18 has the potential for falls due to impaired balance, requires one to one assist with standing and walking short distances and is a high risk for falls. This Care Plan also documents R18 fell on 7/17/24 with new intervention put in place to encourage R18 to stay where she is seated until staff can help her.

The facility's final report and investigation dated 7/19/24 documents R18 had a fall on 7/17/24 while sitting on the side of the bed receiving staff assistance getting dressed and documents that a CT showed: subarticular sclerosis of the medial tibial plateau compatible with nondisplaced impaction fracture injury.

The Progress note dated 7/17/24 at 9:06am documents at "7:45am resident (R18) was being assisted from bed. She was seated on the side of the bed. Resident (R18) scooted to the edge of the bed and slid off of the bed landing first on her knees and then forward on her forehead. No loss of consciousness. Large hematoma to forehead.

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S9999	Continued From page 14	S9999		

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Ice applied". This note also documents R18 received a Skin tear on left upper arm and a bruise to the left knee and complained of pain in her right knee. R18 sent to local hospital for evaluation.

On 07/21/24 at 08:26 AM R18 noted to be lying in bed with a large, raised, pinkish-red bump to left forehead, bilateral eyes with dark, purple discoloration around orbits and chin area. R18 stated that Wednesday (7/17/24) she was getting out of bed when she slid off the side onto the floor hitting her face on the metal base of the over bed table. R18 stated she went to the hospital and was found to have a "crack" in her leg below her right knee. R18 stated she is to wear a brace to her right leg and a brace to her right wrist. Neither brace noted in room.

On 07/22/24 at 12:45 PM R18 noted sitting in wheelchair in room with Lower Extremity brace to right leg and feet on wheelchair pedals. Bruising to face is turning green in color today.

On 07/24/24 at 11:20 AM R18 noted to be sitting alone in her wheelchair in her room. A Falling star sticker noted on R18's door and on her wheelchair.

On 7/24/24 at 09:30 AM V9 (CNA) stated on 7/17/24 that she was assisting R18 with dressing with bed at mid-level when V13 (CNA) came into R18's room to ask a question. V9 stated she turned her head toward V13 and answered question. V13 gasped causing V9 to turn back to R18 and noted R18 laying on the floor. V9 stated she should not have turned away from R18 because fall would not have happened.

On 07/24/24 at 09:40 AM V10 (Registered

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S9999	Continued From page 15 Nurse/RN) stated she was called to R18's room by V13 stating R18 had fallen. V10 entered R18's room and V9 was kneeling next to R18 laying on the floor. V10 stated she assessed R18's vital signs, did a neurological check, cleaned and bandaged skin tear to left arm and assessed R18's range of motion (ROM). During ROM V10 noted a small bruise to R18's left knee and R18 complained of soreness to her right knee. V9 and V13 put R18 in bed and R18 was sent to local hospital for evaluation. "B"	S9999		