STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510163	A. BUILDING: _____ B. WING _____	C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP MANOR OF ILLINOIS	1209 21ST AVE 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
A 000	Initial Comment Original investigation of FRI IL 179267. Violation 295.4010 e) cited.	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Section 295.4010 Service Plan e) The service plan shall be reviewed and revised if necessary immediately after a significant change in the residents physical, cognitive, or functional condition. TYPE 3 VIOLATION Based on record review and interviews, the establishment failed to address and or revise one of three sampled residents service plans as needed. (R1) Findings include: R1's incident reports note that R1's had four unwitnessed falls within a five day period. Falls on 10/3/24, 10/5/24, 10/6/24, and 10/7/24 resulting in no serious injuries. On 10/25/24 at 11:05 A.M., E1 (Administrator of Clinical Services) confirmed R1's four unwitnessed falls. R1's current service plan dated 6/3/24 fails to list "falls" as a potential or current issue. R1's service plans therefore it doesn't list any interventions to	A4010		

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A4010	Continued From page 1 help reduce the risk of R1 from falling. On 10/25/24 at 11:12 A.M., E2 (Memory Care Manager) stated that she is responsible for the Memory Care resident's service plans and confirmed that falls were not addressed on R1's current service plan.	A4010		