STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146099	A. Building B. Wing	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Friendship Manor	1209 21st Avenue Rock Island, IL 61201

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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. 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 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