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 12/13/2013

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	Final Observations STATEMENT OF LICENSURE VIOLATIONS 300.1210b) 300.1210d)6) 300.3240a) 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 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements were not met as evidenced by: Based on observation, record review and interview staff failed to adequately supervise a	S9999		

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S9999	Continued From page 1	S9999		

resident with a hot beverage. This failure resulted in R1 sustaining thermal burns to both thighs. Findings include:

R1's Physician Order Sheet (POS) dated December 2013 includes the following diagnoses: Glaucoma, Arthritis, Osteoarthritis, Osteoporosis and Dementia.

R1's Minimum Data Set (MDS) dated 12/9/13 is coded " moderately impaired vision- not able to see newspaper headlines but can identify objects". R1's eating skills are coded "extensive (staff) assistance required". R1's cognitive patterns are scored "03-impaired".

R1's Incident Report dated 12/3/13 at 11:35 AM states" ...(R1) spilled coffee into lap at lunch...sent to the E.R. (Emergency Room)...".

On 12/13/13 at 10:10 AM, E6 (CNA) stated, " (CNA) yelled at me '(R1)'s been burnt with hot coffee' so I helped put (R1) in bed...(We) took (R1)'s pants off and I saw both of (R1)'s inner thighs were bright red. I knew it was bad, so I left the room and went and got the ADON right away".

On 12/13/13 at 10:00 AM, E5 (LPN) stated, "I was (R1)'s nurse the day (R1) got burned by the hot coffee...The ADON called me and told me to get to (R1)'s room, that (R1) had been burned...When I got there (CNAs) had taken (R1)'s pants off . (R1)'s entire inner thighs were bright red... (R1) was crying and saying 'It burns,it burns'...I stayed with (R1) until the ambulance came and took (R1) to the hospital...

On 12/12/13 at 2:25 PM, E2 (Director of Nurses)

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S9999	Continued From page 2	S9999		

stated," from my investigation into the incident with (R1) on December third, we have concluded that the CNA wheeled (R1) into the Sunshine Dining Room for lunch and placed a cup of hot coffee on the table in front of (R1) and left the room. (CNA) was terminated for leaving a cup of hot coffee with a confused resident... if (CNA) hadn't left that hot coffee with (R1), (R1) wouldn't have gotten those burns".

On 12/12/13 at 11:10 AM, E3 (Dietary Service Manager) stated, " I checked the temperature of the coffee that was served that day, it was 174 degrees...".

On 12/13/13 at 9:45 AM, E4 (Registered Nurse) was observed performing a treatment to R1's thighs. Both inner thighs from just below the peri area to the knees are bright red with multiple large open areas with necrotic tissue scattered through out, hanging. Wound bed is beefy red. Yellow drainage noted on removed bandages. Despite being medicated with a narcotic analgesic, one hour prior to the treatment, R1 yelled out during the entire treatment.

R1's Emergency Room report dated 12/3/13 states "Clinical Impression: Second degree burns of thighs".

(B)