STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005698	A. BUILDING: _____ B. WING _____	C 01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOORINGS OF ARLINGTON HEIGHTS	761 OLD BARN LANE ARLINGTON HTS, IL 60005

(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 01-20-2025/IL184880	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.	S9999		

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S9999	Continued From page 1	S9999		

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.

These Regulations are not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure a resident was transferred safely and, in a manner, to prevent resident injury. These failures resulted in a resident (R1) sustaining a leg laceration during a resident transfer. The resident was sent to a local hospital where she required fourteen sutures to repair her leg laceration. These failures apply to 1 of 3 residents (R1) reviewed for safety and supervision in the sample of 3.

The findings include:

A facility incident report and progress notes dated 1/20/25 showed R1 was found by staff to have a large, bleeding laceration to her right lateral lower leg, immediately after being transferred from her wheelchair to bed by V5 Certified Nursing Assistant (CNA). The incident report showed, "Per CNA (V5) when transferring resident, her right leg scraped on the enabler piece" of the resident's bed frame. The progress notes showed R1 was assessed by V4 Registered Nurse (RN) and found to have a 10 cm (centimeter) x 1 cm laceration to her leg. 911

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S9999	Continued From page 2	S9999		

was called. R1 was transported emergently to a local hospital for an evaluation and treatment.

R1's hospital discharge notes dated 1/20/25 showed R1 was treated for a "large laceration" to her right lower leg that required fourteen sutures to repair. R1 was discharged back to the facility on 1/20/25.

R1's progress note dated 1/21/25 showed R1 was provided with a new bed.

R1's progress note dated 1/23/25 showed R1 was started on antibiotics due to developing redness to the wound on her right lower leg.

R1's admission record showed R1 was admission care plan dated 1/13/25 showed R1 was admitted to the facility with diagnoses of spinal stenosis, history of falling, muscle weakness, unsteadiness on feet, and dementia. R1 was cognitively impaired.

R1's transfer assessment dated 1/13/25 showed R1 required the assistance of 1-2 staff members for transfers.

On 1/29/25 at 9:38 AM, R1 was seated in a wheelchair with a large gauze dressing noted to her right lower leg. R1 stated she didn't remember what happened to her right leg, but she remembers her "leg was bleeding." R1 was unable to state when the incident happened or who was with her at the time of the incident. This surveyor's interview with R1 was limited due to R1's impaired cognition.

On 1/29/25 at 10:24 AM, V5 CNA stated, on 1/20/25, she (V5) had wheeled R1 in her wheelchair into her room to provide cares. V5

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stated she transferred R1 from her wheelchair to the toilet (by herself), using a gait belt. While R1 was seated on the toilet, V5 placed R1 in a nightgown for bed. V5 stated R1 had no bleeding from her right leg at that time. V5 then transferred R1 back into her wheelchair (using a gait belt) and wheeled R1 over next to her bed. V5 transferred R1 from her wheelchair to her bed with a gait belt. V5 stated, "Once I got her on the bed, I noticed her right leg was bleeding. I got the nurse and that's when we saw that she cut her leg on a screw that was sticking out of the bed. Her leg must have scraped against the screw when I put her on the bed." V5 stated, "She never fell. That night, (R1) was tired. She seemed confused. This was my first-time taking care of (R1). I didn't know how she was supposed to be transferred. I asked her if she could stand, and she said yes. (R1) kept saying "I'm ok" so I transferred (R1) myself. I didn't realize she had hit her leg."

On 1/29/25 at 12:04 PM, V4 RN stated she was called into R1's room, by V5 CNA, on 1/20/25. V4 stated she found R1 seated on the side of the bed with a bleeding wound to her right leg. V4 stated, "It appeared that when (V5 CNA) was getting (R1) into bed, her leg brushed against her bed frame where a small (metal) projection was sticking out..."

On 1/29/25 at 12:33 PM, V2 Director of Nursing stated R1's bed was exchanged for another bed on 1/21/25 because she "felt it's what caused her injury. We wanted to prevent further injury."

On 1/29/25 at 1:30 PM, V8 (R1's Physician) stated he had been R1's physician for the past twenty years. V8 stated R1 was recently transferred from assisted living to skilled care due

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S9999	Continued From page 4 to a physical and mental decline in condition. V8 stated, "She (R1) is definitely declining. She has become more confused. She (R1) can't stand up without assistance. She (R1) has severe spinal stenosis and chronic pain." V8 stated, "Yes, I would expect she be transferred in a way that she does not get hurt. When she was in assisted living, she required one assist for transfers. Since being admitted to skilled care, she is bordering on needing a (mechanical) lift for transfers. She (R1) would need at least a two person assist now..." (B)	S9999		