		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			X3) DATE SURVEY COMPLETED		
IL6005698		B. WING			C 03/24/2025			
NAME OF F	IL6005698 B. WING 03/24/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
MOORINGS OF ARLINGTON HEIGHTS 761 OLD BARN LANE								
WOOKIN	GS OF ARLINGTON F	ARLING1	ON 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE		
S 000	Initial Comments		S 000					
	Investigation of Fac 03-14-2025/IL1886	cility Reported Incident of 03						
S9999	Final Observations		S9999					
	Statement of Licens 300.610a) 300.1210d)6)	sure Violations:						
	Section 300.610 R	esident Care Policies						
	procedures governifacility. The written be formulated by a Committee consisti administrator, the a medical advisory conformer and other policies shall comport the written policies the facility and shall	advisory physician or the committee, and representatives or services in the facility. The ly with the Act and this Part. It is shall be followed in operating the reviewed at least annually documented by written, signed						
	Section 300.1210 Nursing and Person	General Requirements for nal Care						
	nursing care shall it	o subsection (a), general nclude, at a minimum, the be practiced on a 24-hour, basis:						
	assure that the resi as free of accident nursing personnel s that each resident r	recautions shall be taken to idents' environment remains hazards as possible. All shall evaluate residents to see receives adequate supervision						
	tment of Public Health Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 04/10/25

TITLE

CTATEMENT OF DEFICIENCIES (VA) DROVIDED/CURRULED/CLIA		(VO) MILITIDI	E CONOTRILOTION	(VO) DATE	OLIDVEN.	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE	SURVEY LETED	
, and i but of contraction individual individual individual in the contraction individual individua		A. BUILDING:			<u></u>	
				C	;	
IL6005698		B. WING		03/2	4/2025	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
		761 OLD I	BARN LANE			
MOORIN	GS OF ARLINGTON H	IFIGHTS	ON HTS, IL			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE	DATE
S9999	Continued From pa	ge 1	S9999			
	and assistance to p	revent accidents.				
	This REQUIREMEN	NT was not meet evidenced by				
	Based on observati	on, interview, and record				
		iled to ensure a resident's				
		fely secured to prevent the				
		from the bed. This failure				
	resulted in R1 falling from her bed to the floor after the mobility bar malfunctioned. R1 sustained a laceration to her left upper arm requiring 16 sutures. This applies to 1 of 3 residents reviewed					
	for safety in the san					
	•	·				
	The findings include:					
	R1's undated Final	Incident and Accident Report				
		ear-old female resident. Ón				
		while CNA -Certified Nursing				
		providing personal care, the				
		vard and fell from bed				
		to left upper armper V5				
		the bed, placed her on the				
	was providing care	a sitting positionwhile (V5) (R1) pushed on the bed				
		ched and (R1) fell forward				
		otained a laceration to the left				
		as sent out to the local				
		ed 16 sutures to her left upper				
	arm					
	On 2/24/25 at 0:45	ANA 1/1 (Administrator) atata d				
		AM, V1 (Administrator) stated nsed intermediate bed.				
		AM, R1 was observed in her				
		wheelchair. R1 had bruising in				
		light to dark purple to her left				
		upper arm. A gauze dressing arm and left upper arm was in				

place. Light color bruising was also on her right

STATE FORM 9K8511 If continuation sheet 2 of 4

etatement of periodicine (V4) province/europide/eu		(VO) MUUTIDI	E CONCERNICATION	(VO) DATE	OLIDVEV	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l` ´com		(X3) DATE COMP	LETED	
JUNE 1 EAN OF CONNECTION		A. BUILDING:			OOMII LETED	
		D WINC		1	С	
IL6005698		B. WING		03/2	4/2025	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MOODIN	GS OF ARLINGTON H	761 OLD E	BARN LANE			
WOOKIN	GS OF ARLINGTON F	ARLINGTO	ON HTS, IL	60005		
(X4) ID PREFIX TAG	ID SUMMARY STATEMENT OF DEFICIENCIES ID FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	CTION SHOULD BE COMPLETE O THE APPROPRIATE DATE	
S9999	9 Continued From page 2 S9999					
\$9999	cheek and right hand. R1 stated she fell but could not recall the details. R1 stated "she pushed me." On 3/24/25 at 10:23 AM, V5 (CNA) stated on 3/14/25, she was assisting R1 with cares. She (V5) sat R1 up on the edge of the bed, she was holding to the side rail, then she went down. The rail unlatched and R1 fell from the bed to the floor. V5 stated she was in front of R1, but it happened so fast, she was not able to stop her from falling. R1 was bleeding from her left upper arm, her arm struck something, but she did not see what she hit. V5 stated she had no idea the side rail was loose, "I thought it was locked." On 3/24/25 at 1:30 PM, V3 (RN-Registered Nurse) stated on 3/14/25, she was in the dining room when she heard someone calling for a nurse. She (V3) entered R1's room, she was laying on the floor next to her bed bleeding. R1 had on her incontinent brief with compression stockings. R1 was not wearing a shirt or pants. R1 had a laceration to her left upper arm and left forearm. She (V3) called 911 and was sent out to the local hospital. She asked V5 what happened, V5 reported she was getting R1 dressed and sat her up at the edge of the bed. R1 was holding on to the bed's grab bar and it went down, and she fell to the floor. V5 reported she was in front of R1 but told her it happened so fast she could not stop R1 from falling. The grab bar was in the downward position with blood on the bar. The grab is for mobility, staff should check to make sure the grab bar is secure. "I think the fall should		\$9999			
	downward position grab is for mobility, sure the grab bar is have been prevente follow cues and con assist with transfers lift.	with blood on the bar. The staff should check to make				

Illinois Department of Public Health

STATE FORM 9K8511 If continuation sheet 3 of 4

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED				
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