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 03/24/2025

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 03-14-2025/IL188603	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 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 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	S9999		

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S9999	Continued From page 1	S9999		

and assistance to prevent accidents.

This REQUIREMENT was not meet evidenced by

Based on observation, interview, and record review the facility failed to ensure a resident's mobility bar was safely secured to prevent the resident from falling 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 sample of 3.

The findings include:

R1's undated Final Incident and Accident Report shows R1 is a 91-year-old female resident. On 3/14/25 at 6:30 AM, while CNA -Certified Nursing Assistant (V5) was providing personal care, the resident leaned forward and fell from bed obtaining laceration to left upper arm .....per V5 she washed (R1) on the bed, placed her on the edge of the bed in a sitting position ...while (V5) was providing care, (R1) pushed on the bed enabler which unlatched and (R1) fell forward from the bed and obtained a laceration to the left upper arm ...(R1) was sent out to the local hospital and required 16 sutures to her left upper arm ....

On 3/24/25 at 9:15 AM, V1 (Administrator) stated R1 resides in a licensed intermediate bed.

On 3/24/25 at 9:32 AM, R1 was observed in her room, sitting in her wheelchair. R1 had bruising in various stages from light to dark purple to her left hand, forearm and upper arm. A gauze dressing wrap to her left forearm and left upper arm was in place. Light color bruising was also on her right

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S9999	Continued From page 2	S9999		

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 have been prevented." R1 is alert to self, she can follow cues and commands, she is a two person assist with transfers with the mechanical stand lift.

On 3/24/25 at 12:23 PM, V2 (DON/Director of

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S9999	Continued From page 3 Nursing) stated V5 reported she was getting R1 up for the morning. She (V5) changed R1 and sat her up on the edge of the bed. R1 was holding onto the bed enabler with V5 in front of her. The bed enabler unlatched, and she (R1) fell from the bed on the floor. Maintenance attaches the mobility bar to the bed; they are secured to the bedframe and should remain upright. The bar was faulty and malfunctioned. CNAs should check to make sure the bar is secure before use and maintenance staff are now making rounds to ensure the bed enablers are secured. R1's Fall Risk Assessment dated 3/2/25 shows she is high risk for falls. R1's Wound Evaluation Report dated 3/17/25 shows wound of the left, upper arm full thickness from a fall, trauma/injury, measuring 3.1 cm (centimeters) x 10.2 cm x 0.2 cm. Wound to the left, proximal forearm full thickness from a fall, trauma/injury measuring 3.1 cm x 2.1 cm x 2 cm. The facility's Residents at Risk for Falls or who have fallen Policy reviewed 5/2024 states, "To ensure that appropriate risk assessments, documentation and care planning are completes for residents at risk for falls or who have fallen. Assess and develop interventions, and/or revise the plan of care for a resident who has experienced falls, or who is identified as having risk factors for falling." (B)	S9999		