

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005698	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/07/2025
---	---	--	--

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	S 000		
	Annual Licensure and Certification			
S9999	Final Observations	S9999		
	Statement of Licensure Violations 1 of 3: 300.610a) 300.615e) 300.615f)			
	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 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information			
	e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility, unless a background check was initiated by a hospital pursuant to the Hospital Licensing Act.			

Illinois Department of Public Health

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

TITLE

(X6) DATE

Electronically Signed

06/02/25

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005698	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/07/2025
NAME OF PROVIDER OR SUPPLIER MOORINGS OF ARLINGTON HEIGHTS		STREET ADDRESS, CITY, STATE, ZIP CODE 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
S9999	<p>Continued From page 1</p> <p>Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act)</p> <p>f) The facility shall check for the individual's name on the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections sex registrant search page at www.idoc.state.il.us to determine if the individual is listed as a registered sex offender.</p> <p>These Regulations are not met as evidenced by:</p> <p>Based on interview and record review the facility failed to ensure resident background checks and/or sex offender checks were completed within 24 hours of admission for new admissions. This applies to 5 of 10 residents (R319, R318, R317, R265, and R264) reviewed for background checks in the sample of 18.</p> <p>The findings include:</p> <p>1. Facility provided Action Summary report for residents admitted in the last month shows R319 was admitted to the facility on 5/1/2025.</p> <p>R319's Criminal History Information Response Process (CHIRP) form has a date of 5/4/25.</p> <p>The rest of R319's background checks and/or sex offender checks are either dated for 5/5/25 or have no date.</p> <p>2. Facility provided Action Summary report for residents admitted in the last month shows R318 was admitted to the facility on 5/2/2025.</p> <p>R318's CHIRP form has a date of 5/4/25.</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005698	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/07/2025
NAME OF PROVIDER OR SUPPLIER MOORINGS OF ARLINGTON HEIGHTS			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
S9999	<p>Continued From page 2</p> <p>The rest of R318's background checks and/or sex offender checks are either dated for 5/5/25 or have no date.</p> <p>3. Facility provided Action Summary report for residents admitted in the last month shows R317 was admitted to the facility on 5/2/2025.</p> <p>R317's CHIRP form has a date of 5/4/25.</p> <p>The rest of R317's background checks and/or sex offender checks are either dated for 5/5/25 or have no date.</p> <p>4. Facility provided Action Summary report for residents admitted in the last month shows R265 was admitted to the facility on 4/29/2025.</p> <p>R265's CHIRP form has a date of 5/1/25.</p> <p>5. Facility provided Action Summary report for residents admitted in the last month shows R264 was admitted to the facility on 4/26/25.</p> <p>R264's CHIRP form has a date of 4/28/25.</p> <p>The rest of R264's background checks and/or sex offender checks are either dated for 4/29/25 or have no date.</p> <p>On 5/7/25 at 11:30 AM, V1 (Administrator) stated that the admissions department runs the resident background checks. V1 acknowledged that some resident background checks, particularly with weekend admissions, were not being completed on time and that they should be completed within 24 hours of admission.</p> <p>Facility Identified Offenders -- Admission to</p>	S9999			

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005698	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/07/2025
NAME OF PROVIDER OR SUPPLIER MOORINGS OF ARLINGTON HEIGHTS		STREET ADDRESS, CITY, STATE, ZIP CODE 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
S9999	<p>Continued From page 3</p> <p>Skilled Nursing or Intermediate Care or Sheltered Care policy dated 4/1/24 states, "Each community will perform criminal and sex offender background checks as required by applicable law, including but not limited to the Illinois Nursing Home Care Act, 210 ILCS 45/ et. seq., as well as 77 Ill. Admin Code 300.615, 300.625, 300.626 and 300.627 for skilled nursing communities..."</p> <p>(C)</p> <p>Statement of Licensure Violations 2 of 3: 300.610a) 300.696d)14)</p> <p>Section 300.610 Resident Care Policies</p> <p>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.</p> <p>Section 300.696 Infection Prevention and Control</p> <p>d) Each facility shall adhere to the following guidelines and toolkits of the Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services, Agency for Healthcare Research and Quality, and Occupational Safety and Health Administration (see Section 300.340):</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005698	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/07/2025
NAME OF PROVIDER OR SUPPLIER MOORINGS OF ARLINGTON HEIGHTS		STREET ADDRESS, CITY, STATE, ZIP CODE 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
S9999	<p>Continued From page 4</p> <p>14) Implementation of Personal Protective Equipment (PPE) in Nursing Homes to Prevent Spread of Novel or Targeted Multidrug-resistant Organisms (MDROs)</p> <p>These Regulations are not met as evidenced by:</p> <p>Based on observation, interview, and record review the facility failed to ensure a resident with a draining pressure wound was on enhanced barrier precautions (EBP) for one of three residents (R1001) reviewed for Infection Prevention and Control in the sample of three.</p> <p>The findings include:</p> <p>R1001's Admission Record dated 5/6/25 shows she was admitted to the facility on 12/23/22 with diagnoses including dementia, mood disturbance, and palliative care.</p> <p>R1001's Order Summary Report dated 5/6/25 does not include orders for Enhanced Barrier Precautions but does include orders for wound care to R1001's back.</p> <p>R1001's Skin Check Note dated 5/1/25 shows R1001 has an unstageable pressure injury to her back.</p> <p>On 5/5/25 at 10:26 AM, there were no signs on R1001's room to show there were any isolation precautions in place. R1001 was observed being transferred into bed. There was a foam dressing that was in place to R1001's back. There was dark drainage, about the size of a half dollar, that was visible from the outside of the foam dressing. V17 Hospice Registered Nurse (RN) and V18 Hospice Certified Nursing Assistant (CNA) removed the soiled dressing from R1001's wound</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005698	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/07/2025
NAME OF PROVIDER OR SUPPLIER MOORINGS OF ARLINGTON HEIGHTS		STREET ADDRESS, CITY, STATE, ZIP CODE 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
S9999	<p>Continued From page 5</p> <p>on R1001's back. V11 RN came into R1001's room to clean R1001's wound and replace the dressing to R1001's back. V11, V17, nor V18 had a gown on.</p> <p>On 5/6/25 at 1:28 PM, V3 Infection Preventionist stated residents that have wounds should have EBP in place. V3 stated EBP is in place to protect the resident from getting infections. V3 stated staff should wear gowns and gloves when performing high contact activities with the residents.</p> <p>The facility's Infection Control Policy revised 5/31/25 shows, "The purpose is to ensure [facility] establishes and maintains an Infection Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown, and gloves use during high contact resident care activities."</p> <p>(C)</p> <p>Statement of Licensure Violations 3 of 3: 300.1210b) 300.1210d)2)5)</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005698	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/07/2025
NAME OF PROVIDER OR SUPPLIER MOORINGS OF ARLINGTON HEIGHTS		STREET ADDRESS, CITY, STATE, ZIP CODE 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
S9999	<p>Continued From page 6</p> <p>care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.</p> <p>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:</p> <p>2) All treatments and procedures shall be administered as ordered by the physician.</p> <p>5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.</p> <p>These Regulations are not met as evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to ensure a pressure injury was identified prior to becoming a deep tissue injury wound and failed to ensure pressure injury prevention interventions were in place. This applies to 2 of 3 residents (R1001, R1002) reviewed for pressure injury in the sample of 3.</p> <p>The findings include:</p> <p>1. R1001's Admission Record dated 5/6/25 shows she was admitted to the facility on 12/23/22 with diagnoses including dementia, mood disturbance, and palliative care.</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005698	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/07/2025
NAME OF PROVIDER OR SUPPLIER MOORINGS OF ARLINGTON HEIGHTS			STREET ADDRESS, CITY, STATE, ZIP CODE 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
S9999	<p>Continued From page 7</p> <p>R1001's Wound Identification and Assessment dated 4/15/25 shows a new wound was identified on 4/15/25. This wound was a facility acquired deep tissue injury pressure injury to R1001's right side mid back. The wound measured 1.7 centimeters (CM) long and 1.5 CM wide. The depth was unknown. The wound bed color was black.</p> <p>R1001's Skin Check Note dated 5/1/25 shows R1001's wound was now an unstageable pressure injury that measured 2 CM long and 2 CM wide. The depth measured 0.1 CM.</p> <p>On 5/7/25 at 11:57 AM, V9 Wound Care Nurse stated R1001 has an unstageable pressure injury to her back. V9 stated that there should have been some redness to R1001's skin prior to becoming an unstageable pressure injury.</p> <p>2. On 5/6/25 at 9:44 AM, R1002 was sitting in her wheelchair in her room. R1002's posterior left heel was resting on the leg rests. R1002 had a positioning wedge sitting on the love seat in her room.</p> <p>On 5/6/25 at 9:44 AM, R1002 said, I have a wound to my left heel and buttocks. My buttocks hurts when I am sitting up in my chair. I have a cushion on my wheelchair, the staff are saying I should get an air cushion for my chair, to help my pressure ulcer. The CNA-Certified Nursing Assistant will use that positioning wedge, on the couch, to position me off my pressure ulcer. When it's in place it helps a lot. I was told that they had to quit using it because there was no Physician's Order to use it. The physician's order has not come through yet.</p>	S9999			

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005698	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/07/2025
NAME OF PROVIDER OR SUPPLIER MOORINGS OF ARLINGTON HEIGHTS			STREET ADDRESS, CITY, STATE, ZIP CODE 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
S9999	<p>Continued From page 8</p> <p>On 5/6/25 at 10:05 AM, V9 Wound Nurse said, there is usually a pillow underneath R1002's legs. When the pillow is underneath her legs there is no pressure placed on the heel wound. The heel wound is a venous wound due to circulation. The pressure ulcer on R1002 ischium is due to sitting in the wheelchair. R1002 has been using a wedge to off load the pressure. The wedge "should be put on when they put her in the chair."</p> <p>On 5/6/25 at 10:13 AM, V10 CNA said, "I forgot to put the wedge on."</p> <p>R1002's current Care Plan on 5/6/25 shows, "off load heels at all times."</p> <p>R1002's current Physician's Orders on 5/6/25 shows, "may use wedge cushion to help offload while sitting in wheelchair per patient request every shift. Elevate: Left heel at all times while in bed and when in wheelchair with leg elevated."</p> <p>(B)</p>	S9999			