

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146191	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2025
NAME OF PROVIDER OR SUPPLIER Mado Healthcare - Uptown		STREET ADDRESS, CITY, STATE, ZIP CODE 4621 North Racine Avenue Chicago, IL 60640	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46342</p> <p>Based on interview and record review, the facility failed to protect resident's right to be free from physical abuse. This failure affected one (R1) out of three residents reviewed for abuse.</p> <p>Findings include:</p> <p>On 04/22/25 at 11:30 AM, R1 stated R2 tried to choke him when R1 was in the 1st floor dining room doing activities. R1 stated, R2 came up from behind R1 and grabbed R1 around the neck with R2's arm. R1 stated he was not expecting it, so he was surprised when R2 did that. R1 stated one of the staff got R1 off R2 and R2 was removed from the room. R1 does not remember if R2 said anything as he was trying to choke R1. R1 stated R2 did not look angry and I don't know why he did that.</p> <p>On 04/22/25 at 11:10 AM, observed R2 sitting in his bedroom looking at an opened bible on his bedside table. V21 (Business Office Manager) acted as translator because R2's primary language is Spanish. R2 stated via V21 that God, told me to choke him (R1) so I did and God told me to do this because he (R1) was going to try to choke me first. R2 stated via V21 that R1 never touched or threatened R2 and the only reason R2 tried to choke R1 was because God told R1 to do it.</p> <p>On 04/23/25 at 11:10 AM, via phone interview V3 (Former Activity Aide) stated he was running the activity group in the morning in the 1st floor dining room on the day R2 tried to choke R1. V3 stated that on that day R2 walked into the 1st floor dining room and came up from behind R1 and got R1 in a head lock using his arms. V3 stated he could see that R2 was trying to choke R1. V3 stated he had to pull R2's arm off from around R1's neck. V3 stated once he separated them, R2 told V3 that God told R2 to kill somebody, not specifically R1, just somebody. V3 stated he was the only staff in the room when this happened, and he does not remember the names of the other residents in the room at the time.</p> <p>On 04/23/25 at 12:22 PM, V21 (Business Office Manager) stated on 02/04/25, the former administrator called her downstairs to translate for R2 after the altercation had occurred between R1 and R2. V21 stated R2 told her that he (R2) was trying to kill R1 because God told him to. V21 stated R2 said he put his arm around R1's neck to choke him. V21 stated R2 said R2 did that because R1 was going to hurt R2, so God told R2 to hurt R1 first. V21 stated R2 said he was trying to kill R1, not just hurt R1. V21 stated R2's story on 02/04/25 was the same he told us yesterday (04/22/25), no changes.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/22/25 at 10:51 AM, V5 (Licensed Practical Nurse) stated on 02/04/25, she was notified that there had been an altercation between R1 and R2 and she assessed each of them. V5 stated R1 told her, R2 grabbed me from behind. V5 stated R1 denied being in pain anywhere and there were no signs or symptoms of any injury. V5 stated R1 told her I don't know, muchacha, I don't know, muchacha and R2 was calm, not agitated. V5 stated R2 does have a history of schizophrenia and does hallucinate saying things like God told me I need to drink water or God told me</p> <p>On 04/23/25 at 11:45 AM, V1 (Administrator) stated he is the abuse coordinator at the facility and has been working at the facility for two months. V1 stated the main goal is to prevent abuse and to keep the residents free from abuse. V1 stated the residents living at the facility are a vulnerable population and it is the staff/facilities responsibility to advocate for the residents and keep them safe from abuse. V1 stated R2 choking R1 is physical abuse. V1 stated he does not think the action was intentional, but it was willful on R2's part because R2 was responding to the inner voice inside his head telling R2 to take the action of trying to choke R1.</p> <p>R2's nursing progress note dated 02/04/25 entered by V5 documented, Writer was notified at about 11am that resident was aggressive and meet criteria for psychiatric evaluation. Resident is to be sent to St Mary's Hospital for psychiatric evaluation and indicated that R2's son, primary care provider, and psychiatric nurse practitioner were notified.</p> <p>R2's Petition for Involuntary/Judicial admitted d 02/04/25, 11:30 AM documented in part, client is presenting below baseline. Displaying socially intrusive and aggressive behavior directed toward people in immediate environment secondary to psychosis. Client choked a co-peer believing God told him to. In need of immediate hospitalization for psych evaluation and to prevent harm to others.</p> <p>Facility reported incident written witness statement received 02/04/25 at 11:00 AM documented in part, I, (V3) witnessed R2 choking R1 around the neck in a choke hold yelling, God told me to kill him. The written statement also the incident happened in the dining room during morning group at 10:15.</p> <p>R1's admission record indicates admitted on 01/03/25 with diagnosis including but not limited to Chronic Obstructive Pulmonary Disease, Chronic Sinusitis, Dysarthria and Anarthria, Schizophrenia, Osteoarthritis of Knee, Insomnia, Slurred Speech, Essential (Primary) Hypertension. R1's MDS ([NAME] Data Set) dated 01/21/25 indicates intact cognition. R1 has care plan in place stating R1 is at risk for abuse/neglect.</p> <p>R2's admission record indicates admitted on 11/24/21 with diagnosis including but not limited to Chronic Obstructive Pulmonary Disease, Unspecified Dementia, Unspecified Severity, with Other Behavioral Disturbance, Mild Cognitive Impairment of Uncertain or Unknown Etiology, Essential (Primary) Hypertension, Unspecified Schizophrenia, Schizoaffective Disorder, Bipolar Type, Alcohol Dependence, In Remission. R2's MDS dated [DATE] indicates intact cognition. R2 has care plans in place for audio hallucination/preoccupation with religion, felony history for aggravated stalking and risk for abuse/neglect.</p> <p>Facility provided document titled, Illinois Long-Term Care Ombudsman Program Residents' Rights for People in Long Term Care Facilities dated 11/18 documents in part, your rights to safety: You must not be abused, neglected, or exploited by anyone- financially, physically, verbally, mentally, financially or sexually.</p> <p>(continued on next page)</p>		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility provided document titled, Abuse Policy dated 01/04/24 which documents in part, that each resident will be free from Abuse Abuse can include verbal, mental, sexual, or physical abuse . Additionally, resident will be protected from abuse, neglect, and harm while they are residing at the facility.		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>47304</p> <p>Based on interview and record review, the facility failed to (a) assess and document pressure ulcer characteristics and measurement on a weekly basis and (b) ensure that the orders provided by wound nurse practitioner (NP) were performed to 1 (R3) out of 3 residents reviewed for Improper nursing care.</p> <p>The findings include:</p> <p>R3's admission record showed initial admitted on 5/19/2021 with diagnoses not limited to Acute respiratory failure with hypoxia, Pressure ulcer of right heel stage 3, Morbid (severe) obesity due to excess calories, Chronic respiratory failure with hypoxia, Pressure ulcer of right buttock stage 2, Unspecified diastolic (congestive) heart failure, Acute embolism and thrombosis of unspecified deep veins of right lower extremity, Unspecified urinary incontinence, Type 2 diabetes mellitus, Schizoaffective disorder, Chronic obstructive pulmonary disease. R3 was discharged from the facility on 4/15/2025.</p> <p>On 4/22/25 at 10:25AM V5 (LPN / Licensed Practical Nurse) stated wound treatment is done by nurse on duty, had regularly worked and provided treatment to R3's wounds (Sacrum and Right heel). She said R3 had wound on sacrum area and treatment was Santyl and Foam dressing. V5 said R3 's wound to right heel, treatment was Xeroform.</p> <p>On 4/22/25 at 11:22am V10 (MDS coordinator, LPN) stated R3 had 2 pressure ulcers, 1 Stage 2 to sacral / right buttock and 1 Stage 3 to Right heel and were present upon readmission.</p> <p>On 4/22/25 At 1:04PM V8 (Wound NP) stated has been servicing the facility for 2 years and seeing wounds in the facility. Stated he has been following R3's wounds. Surveyor reviewed R3's EHR (Electronic health record) with V8 and said R3 had pressure ulcers, Stage 2 to sacrum and Stage 3 to right heel. Reviewed V8's wound documentation dated 4/8/25 and said treatment for sacrum and right heel was Hydrofera. V8 stated is it important to follow treatment order to promote wound healing and prevent complication like worsening or deterioration of wound. V8 stated the purpose of Hydrofera treatment is to keep the wound moist and promote healing. He said Santyl is a chemical debriding agent. V8 said Santyl to Right buttock / Sacrum should have been discontinued and changed to Hydrofera. He said R3's wound visit was on 3/1/25 then 3/26/25 and 4/8/25. V8 stated no wound visit on 3/8/25, 3/15/25, 3/22/25 and 4/1/25. He said it is important to assess wound and document at least weekly to monitor if treatment is appropriate and if need to be changed, it will also monitor progress of the wound and if the wound is not improving treatment should be changed.</p> <p>On 4/22/25 At 2:36pm V2 (DON / Director of Nursing) stated it is important to carry out and follow wound NP's order for wound treatment. She said wound NP's order should be placed in POS (Physician order sheet) and TAR (Treatment administration record). V2 said purpose of wound treatment is to promote healing of the wound. She said if wound treatment is not followed, potentially can lead to wound deterioration / complications. V2 said it is important to assess and document wound at least weekly to monitor the progress of the wound.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>MDS (Minimum Data Set) dated 3/4/25 showed R3's cognition was intact. She needed Substantial / maximal assistance with oral hygiene, upper body dressing; Dependent with toileting and personal hygiene, shower / bathe self, lower body dressing, chair / bed and toilet transfer. R3 was always incontinent of bladder and frequently incontinent of bowel. MDS showed R3 had 1 Stage 2 and 1 Stage 3 pressure ulcers that were present upon admission.</p> <p>V8 (Wound NP/Nurse Practitioner) follow up wound documentation dated 4/8/25 showed in part:</p> <ul style="list-style-type: none"> - Sacrum pressure ulcer Stage 2 orders: cleanse wound using normal saline solution, pat dry using gauze. Apply Hydrofera on wound bed. Apply ABD pad on wound and secure with tape. - Right heel pressure ulcer Stage 3 orders: cleanse wound using normal saline solution, pat dry using gauze. Apply Hydrofera on wound bed. Apply Hydrofera on wound bed. Apply rolled gauze and secure with tape. <p>R3's order summary report dated 4/22/25 with order not limited to:</p> <ul style="list-style-type: none"> - Santyl External Ointment 250 UNIT/GM (Collagenase) Apply to Sacrum topically one time a day related to pressure ulcer of right buttock Stage 2. Cleanse sacrum with NS, apply Santyl ointment, cover with gauze, secure with ABD pad. - Xeroform Petrolat Patch 2 (Bismuth Tribromophenate-Petrolatum) Apply to Right heel topically one time a day related to pressure ulcer of right heel, stage 3. Apply to right heel topically every day shift for wound treatment on the right heel post saline cleansing then cover with gauze dressing and wrap with kerlix until healed. <p>R3's TAR (Treatment Administration Record) schedule for April 2025 showed in part:</p> <ul style="list-style-type: none"> - Santyl External Ointment 250 UNIT/GM (Collagenase) Apply to Sacrum topically one time a day related to pressure ulcer of right buttock Stage 2. Cleanse sacrum with NS, apply Santyl ointment, cover with gauze, secure with ABD pad. Start date 3/26/25. Discontinue date 4/16/25. - Xeroform Petrolat Patch 2 (Bismuth Tribromophenate-Petrolatum) Apply to Right heel topically one time a day related to pressure ulcer of right heel, stage 3. Apply to right heel topically every day shift for wound treatment on the right heel post saline cleansing then cover with gauze dressing and wrap with kerlix until healed. Start date 3/6/25. Discontinue date 4/16/25. <p>Care plan dated 3/18/2025 showed in part: R3 has alteration in skin integrity related to Breakdown (right buttock wound, right heel wound). Conduct wound assessment and observation per facility protocol</p> <p>Facility was not able to provide R3's weekly wound assessment / documentation on 3/8/25, 3/15/25, 3/22/25, and 4/1/25.</p> <p>Facility's skin management guidelines policy dated 3/2016 documented in part: Document findings, wound characteristics, stage (if applicable), wound measurements in centimeters (cm), pain associated with wound on the weekly wound documentation form. Notify the physician, obtain treatment orders and document orders on TAR (Treatment administration record).</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Facility's wound care / prevention policy dated 1/2025 showed in part: Ensure that the orders provided by physician are performed as ordered.</p>		