STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146191	A. Building B. Wing	05/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mado Healthcare - Uptown	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44314 Based on observation, interview, and record review, the facility failed to follow their policy by failing to notify the nurse on duty of a resident fall and failed to ensure that a resident was immediately assessed by a nurse after sustaining a fall. This failure effected 1 resident (R1) out of 5 residents reviewed for falls in a total sample of seven residents. Findings include: Facility Final Incident Investigation (dated 04/25/2025) documents in part: The certified nursing assistant stated that in the morning he went to the room of R1 and he was sitting on the floor. He tried to get him up from the floor. Staff denied being physically aggressive towards R1. He denied causing any harm to R1. The facility is unable to substantiate the allegation of physical abuse. There was no ill-intentions or intentional act towards R1. R1 sustained a close fracture of the right shoulder. Staff were in-serviced on 04/22/2025, on appropriate transfer practices. Fall Prevention Policy (undated) documents in part: It is the policy of this facility to provide the highest quality care in the safest environment for the individuals residing in the facility. Immediate action when a resident is found on the floor: do not move the individual; Call for assistance. Do not leave the individual alone; The nurse will immediately assess the individual for injury. R1's Face Sheet documents resident is a [AGE] year-old with diagnoses including but not limited to: nondisplaced fracture of surgical neck of right humerus, initial encounter for closed fracture, pain in right shoulder, bipolar disorder, primary osteoarthritis left shoulder. Minimum Data Set Section (MDS) section C (dated March 04, 2025) documents that R1 has an Interview for Mental Status (BIMS) score of 14, indicating that R1's cognition is intact. Care plan (03/04/2025) documents that R1 has potential for joint pain/discomfort due to diagnosis of osteoarthritis left shoulder. On 05/03/2025, at 10:14 AM, surveyor observed R1 lying in bed on his left side. R1 was observed with a bruise on the right arm. Surveyor interviewed R1 about the fracture of the right shoulder that R1 sustained from a fall on 04/21/2025. (continued on next page)

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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/03/2025, at 12:09 PM, V3 (S1/certified nursing assistant) stated, I was the certified nursing assistant that was assigned to R1 on 04/21/2025. R1 is a resident that I care for regularly. Around 9:00 AM, I gave R1 a towel because R1 was going to shower. That day was not R1's scheduled shower day, but I shower R1 every day. R1 is ambulatory and walks to the bathroom independently. When R1 has a bowel movement, R1 does not wipe his buttocks after the bowel movement. I was going to shower R1 because he just finished having a bowel movement and he did not wipe his buttocks. After I handed R1 the towel, I told him to go to the shower room and I told him that I'm coming. I had to go and attend to another resident who could not walk. I was with the other resident about 8 to 10 minutes and then I went to the shower room to meet R1, but R1 was not in the shower room. I went to R1's room, I observed R1 sitting on the floor with his legs straight. R1 was wearing pants and gym shoes while R1 was sitting on the floor. When I walked out of R1's room to check on another resident, R1 was sitting on the bed. When I returned to R1's room, R1 was sitting on the floor. I asked R1 why he was still in his room. R1 told me that he is suffering from his right arm. I grabbed R1's pants from the back and I got him up. R1 stood up. When R1 stood up, I pulled R1's pants and diaper down and R1 was full of poop. R1 said that he is not going to shower because R1's right arm hurts too much. I cleaned R1 up while R1 was standing up. After I changed R1, I told R1 to sit on the bed. R1 eats downstairs, so I told R1 to go and eat downstairs. R1 said that R1 does not want to go because his arm is in too much pain. When R1 told me that he's not going to go eat downstairs, I told my nurse. I told the nurse on duty, V7 (licensed practical nurse), that R1 cannot go downstairs to eat and that R1 broke his arm. I went downstairs and brought R1 his tray. I asked R1 what he was doing on the floor, but he did not respond to me, so I asked him what he was still doing in his room. He said that his right arm hurts. R1 did not tell me how he fell . I would always go and supervise R1 in the shower room because R1 would go and wet the towel and pretend that he was taking the shower. R1 is needs supervision in the shower room. Normally I go with R1, but I needed to mop the floor because another resident peed in the hallway. When I see the resident on the floor, I am not supposed to pick up the resident from the floor without a nursing assessment. Picking up R1 from the floor was the mistake I made. I informed the nurse that R1 had a fall after R1 was already in bed and after R1 told me that R1 is going to stay in bed for breakfast due to his right arm pain. When a resident has a fall, the policy is to inform the nurse right away, which I did not do. After I informed the nurse that R1 had a fall and that R1's arm was hurting, V7 went to assess the resident. R1 was sent to the hospital. The mistakes I made is that I transferred R1 post fall without informing the nurses and without the nurse's assessment. R1 slipped off the bed and fell on his right arm. I never stretched is arm and never pulled on his shoulder when I was getting R1 up. I just pulled R1 by his pants. I did not ask for assistance from other staff to transfer R1 to bed post fall, I lifted him by myself. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/03/2025, at 2:41 PM, V1 (administrator) stated, I investigated the incident that occurred on 04/21/2025. I got a call from the hospital that R1 was claiming that R1 was physically abused by the staff. I immediately initiated the investigation. V3 (S1/certified nursing assistant) was the certified nursing assistant that was assigned to R1. V3 was immediately suspended and sent home, pending investigation. R1 was not in the building at the time that the investigation was started, R1 was in the hospital. Then I got another call around 4:30 PM from R1's V12 (primary physician). He verbalized what the resident was claiming about the incident. I explained to the physician that I initiated the investigation and the physician shared that he had spoken to the emergency room doctor. The emergency room doctor had concluded that R1's right arm fracture was not as a result of physician abuse. V12 recommended that we in-service nursing staff and certified nursing assistants on proper transfer techniques. We spoke to the physical therapist to initiate the in-services. The resident was readmitted to the facility later that day. The following day on 04/22/25, I interviewed R1. R1 shared that he was on the floor and V3 lifted him up from the back. His hand gave out when the C.N.A. lifted him up. When he was asked if he feels it was an intentional physical aggression, R1 said no, it was not intentional. R1 was re-interviewed by me. He stated that he was sitting on the edge of the bed and the C.N.A tried to lift him up by his arm and that's how R1 sustained the fracture. He again said that he doesn't think it was intentional. We interviewed other residents and residents never accused this particular C.N.A. of being abusive or aggressive towards the resident. Staff were interviewed on abuse and reporting of abuse. All the staff in the facility receive abuse prevention training monthly and as needed. A C. N.A should not pick up a resident after a resident sustained a fall because it can cause injury without a nursing assessment. V3 should have first notified the nurse on duty to assess R1 when R1 fell . Based on the recommendation from the nurse, we can get then get the resident up from the floor. It is never ok for a C. N.A to pick up a resident from the floor post fall without notifying the nurse and without nursing assessment. On 05/03/25, at 3:03 PM, V2 (director of nursing) stated, After interviewing V3 (S1/certified nursing assistant), we educated V3 about proper transfers. V3 says that R1 was sitting on the floor, however, V3 and other staff should never assist a resident from the floor alone without notification of the nurse. The nurse must complete an assessment first to see if it is safe to transfer the resident from the floor post fall. We educated V3 on never assisting a resident post fall alone, without other staff assistance. All the nursing staff were educated about proper transfers and therapy demonstrated proper and safe transfers. On 05/03/2025, at 3:12 PM, V13 (restorative director) stated, R1 transfers independently with stand-by supervision. R1 requires stand-by assistance for showers. R1 is moderate assistance with shower. R1 requires staff encouragement for showers. R1 did not have any prior falls, prior to 04/21/2025. R1 did not tell me that he had a fall. I asked R1 if he had a fall, but R1 did not confirm that R1 fell . R1 just told me that he went to the hospital. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/03/2025, at 3:34 PM, V7 (licensed practical nurse) stated, On 04/21/2025, I was working on the 4th and 5th floor. While I was on the 5th floor, V3 (S1/certified nursing assistant) alerted me that a resident is hurt. I went to assess R1. R1 was sleeping in his bed. I opened the resident's chart to see if he has any pain medications. I see that R1 has a prescription for pain medications for shoulder pain. I got the pain cream and I went to R1's room to apply the cream. That's when R1 told me that the shoulder that the cream is prescribed for is not what was causing the pain. I was not told that the resident had a fall. I was told by V3 that R1 is having pain. When the resident told me that his right arm is hurting, that's when I did the assessment. While I was assessing R1, that's when R1 alleged that V3 twisted his arm. I was still not informed about a fall; I was only informed by the resident that the C.N.A twisted R1's arm. R1's right arm was visibly swollen. R1 was not able to do range of motion and move his arm due to excruciating pain. I asked R1 how long R1 was having this pain. R1 told me that he was having pain since this morning. I followed the facility protocol and if there is an alleged abuse allegation, we report it to the abuse coordinator who is the administrator. From there the administrator will give me the directives on what to do next. The whole time during R1's assessment, I was not informed at all that a had had taken place. R1 only reported an alleged abuse allegation that V3 twisted his arm, but the C.N.A never told me that a fall occurred. V3 only told me that R1 is having difficulty moving his arm. R1's Progress Note (dated 04/21/2025) documents, Resident complained of right arm swelling. Assessment done. Swelling noted on said arm. He admits to excruciating pain. Range of motion is limited. Resident cannot abduct right arm. Physician notified and responded with order to send resident to community hospital for medical evaluation. Nurse to nurse report given and an estimated time of arrival of 30 min obtained from ambulance. Resident left the facility accompanied by 2 EMT (emergency medical transport) staff without incident. Family member notified via voice mail. R1's Progress Note (dated 04/21/2025) documents, Follow up call made to community hospital regarding patient's status. Spoke with the nurse. That resident will be returning to facility. That patient will be on a sling. Incoming to follow up with return. R1's Progress Note (dated 04/21/2025) documents, Resident returned back to the facility via medical transport. Arrived with 2-person assist on a stretcher. Received alert and oriented at baseline. emergency room discharge documentation confirmed fracture to the right arm with sling in place. Assessment of swelling noted around the scapula region, resident denies pain at this time. No facial grimacing observed. Discharge order for resident is to schedule an appointment with physician (Orthopedic surgery). Physician notified of resident's return, new order for Tylenol 325mg; take 2 tabs by mouth every six hours hours as needed for pain. Order received and carried out. Director of nursing notified. Message left for emergency contact (daughter). Monitoring in place. Vitals stable. R1's Emergency Record (dated 04/21/2025) documents that R1's diagnosis was closed fracture of right shoulder.