Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING: _			
		IL6009013	B. WING		09/23/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
MADO HE	ALTHCARE - UPTOWN	4621 NOI	RTH RACINE AV	ENUE		
IIIADO IIE	ALTIOAKE OF TOWN	CHICAGO	O, IL 60640		1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
S 000	Initial Comments		S 000			
	Complaint Investigation	on: 2486750/IL177128				
S9999	Final Observations		S9999			
	Statement of Licensu	re Violations (1 of 2)				
	300.1830a) 300.1830b)					
	300.1830c) 300.3240a)					
	300.3240a)					
	300.3240d)					
	Section 300.1830 Re Residents' Property	ecords Pertaining to				
	resident's belongings and personal property safekeeping. This rec time of admission and	all maintain a record of any , including money, valuables y, accepted by the facility for cord shall be initiated at the d shall be updated on an ade part of the resident's				
	from the resident's pe	ses are made for a resident ersonal monies, receipts retained that verify the ms purchased.				
	maintained by the factransactions affecting Each individual resideresident's representations.	okkeeping system shall be illity which accounts for all each resident's account. ent, or the individual tive, shall have access to vidual resident's account.				
	Section 300.3240 Ab	use and Neglect				
linaia Danartr	nent of Public Health		J			

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Electronically Signed 10/14/24

Illinois Department of Public Health

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
7.11.2.1.2.1.1.1	5. GGT1267.1611	.52	A. BUILDING: _		00 22.25
		IL6009013	B. WING		C 09/23/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE ZIP CODE	
NAME OF T	NOVIDER OR GOLT EIER		TH RACINE AV		
MADO HE	ALTHCARE - UPTOWN	CHICAGO,			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
\$9999	employee or agent of neglect a resident. (Section aware of abuse or neglect immediately report the writing to the resident Department. (Section d) When an invesuspected abuse of a upon credible evidence long-term care facility abuse, that employee from any further contafacility, pending the oinvestigation, prosecuagainst the employee. These requirements which is the second against the facility abuse and second interview and failed to establish a syresident's funds and second funds against theft, facility against theft, facility against the finds against the finds against the finds against the finds against the resident was to the resident resident was to the resident resid	ensee, administrator, a facility shall not abuse or Section 2-107 of the Act) inistrator who becomes glect of a resident shall e matter by telephone and in 's representative and to the a 3-610(a) of the Act) estigation of a report of resident indicates, based be, that an employee of a is the perpetrator of the eshall immediately be barred act with residents of the autome of any further ation or disciplinary action and record review, the facility evere not met as evidenced and record review, the facility extension of the elongings, and failed to the ess of online purchase for e facility. These failures incurring fraudulent debit R1's and R6's bank 10:15am, with V11 (PRSC tion Services Coordinator)	S9999		
		r requested R1 to elaborate.			

Illinois Department of Public Health

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Illinois Department of Public Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		IL6009013	B. WING		C 09/23/2024
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE. ZIP CODE	1 03/23/2024
	10115211 011 001 1 21211		H RACINE AV		
MADO HE	ALTHCARE - UPTOWN	CHICAGO,			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
S9999	Continued From page 2		S9999		
	R1 stated "I don't want to talk to you anymore." On 09/04/2024 at 2:58pm, V4 (Business Office Manager/Payroll Specialist) stated (R1)'s wallet was given to (V4) by (V6- Admissions Coordinator) on 06/19/2023 for safekeeping.				
	Coordinator) stated it PRSC) who gave me	02pm, V6 (Admissions was (V27 R1's Former (R1)'s wallet and I told			
	(V27) it is not my department; it was (V4). I wrote the date it was handed to me by (V27). I handed it to (V4) the same day. I did not take anything from				
		neck what's in the wallet. I (V4) and I did not check t.			
	residents come with them in my office righ unless he needed the withdraw money hims store. The social serv withdraw money from	the bank or go to store to from the store. For (R1) it hiatric Rehabilitation			
	Manager/Payroll Speclog for the cabinet where resident's wallet. I and access to the wallet. In the manila envelope. The manila envelope to (V5- PRS) bring the manila envelope to (R1)'s debit and creditakes the manila envelope.	05am, V4 (Business Office cialist) stated I don't have a ere I keep (R1)'s and other d (V1 - Administrator) have We both have keys. When I don't take the wallet out of I give the whole manila CC). When they (R1 and V5) elope back, I don't look if t cards are there. Only (V5) elope from me. (V5) was in floors, so whenever (R1)			

Illinois Department of Public Health

STATE FORM 5899 Z40211 If continuation sheet 3 of 20

Illinois Department of Public Health

NAME OF PROVIDER OR SUPPLIER IL6099013 STREET ADDRESS, CITY, STATE, 2IP CODE 4821 NORTH RACINE AVENUE CHICAGO, IL 60640 CHICAGO, IL 60640 SUMMAP STATEMENT OF GETICIENTES (FACH EPICKEN'N WIST THE PRECEDED BY PULL PRECED (FACH EXPRESSION TO BE ADDRESS) GETICIENTS S9999 Continued From page 3 goes to store it falls on (VS) to take him. (V11- PRSC) is now assigned to 4th floor and (V5) continues to still go with (R1) to the store and it is also (V5) who would bring the whole manilal erivelope back to me. I did not check to make sure everything is in the wallet when it was returned to me and when I gave it to (VS), I did not show (V5) what would day theft, honestly to avoid theft of residents Items. I never took (R1)'s wallet and made ATM withdrawais. It is possible the debit card was not in the wallet when it was returned to me because id did not check the contents of (R1)'s wallet. On 09/04/2024 at 3:22pm, this surveyor showed V5 (PRSC) Psychiatric Rehabilitation Services Coordinator) R1's Release of Responsibility For Leave Of Absence Forms, dated 02/2024 to 06/2024 to 06/2024 at many present the space provided for PATIENT OR NEAREST RELATIVE. V5 stated these (items) are something that we (V5 and R1) got from R**. W6 (V5 and R1) went out on that day. Some of them were returned because it was too big or not his style. I cart recall how many were returned. On 09/04/2024 at 3:35pm, V5 stated (R1) made withdrawais mostly at (R1) to fall. When I went out with (R1), the tem. I am probably 5 feet	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		'	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STRTE, 2IP CODE 4821 NORTH RACINE AVENUE CHICAGO, IL 80640 CHICAGO, IL 80640 SUMMANY STRTEMENT OF DESCRINGES (EACH DEPRICES WINDER OF DESCRINGES) (EACH DEPRICES WINDER OF DEPRICES WINDER) S9999 Continued From page 3 goes to store it falls on (V5) to take him. (V11- PRSC) is now assigned to 4th floor and (V5) continues to still go with (R1) to the store and it is also (V5) who would bring the whole manila envelope back to me. I did not check to make sure everything is in the wallet when the manila envelope was returned to me and when I gave it to (V5), I did not show (V5) what was in the wallet. I should have made a binder, so they sign what they take to avoid any theft, honestly to avoid theft of residents' items. I never took (R1')s wallet and made ATM withdrawals. It is possible the debit card was not in the wallet when it was returned to me because I did not check the contents of (R1')s wallet. On 09/04/2024 at 3:22pm, this surveyor showed V5 (PRSC Psychiatric Rehabilitation Services Coordinator) R1's Release of Responsibility For Leave Of Absence Forms, dated 02/2024 to 08/2024, and inquired if (V5) recognized the signature/staff on the space provided for PATIENT OR NEAREST RELATIVE. V5 stated "that's me." This surveyor requested V5 to review the PRSC notes on 30/07/2024. V5 stated these (items) are something that we (V5 and R1) got from R"*. We (V5 and R1) got from R"*. We (V5 and R1) got from R"*. We (V5 and R1) under withdrawals mostly at (R1's bank), I never recall any withdrawals under of R1's bank), I never recall any withdrawals under of R1's bank), I never recall any withdrawals under of R1's bank), I in were steaded of R1's bank), I in the wallet with the with	7440127410	or derived their	IBENTI IO/MIGIN MONIBER.	A. BUILDING: _		001111	
MADO HEALTHCARE - UPTOWN Maj ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION (CAS) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY PLLL) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY PLLL) PREFIX (EACH DEFICIENCY OR LEG IDENTIFYMG INFORMATION) DREFT PREFIX TAG			IL6009013	B. WING		1	
CALL STATE CAL	NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	ITE, ZIP CODE		
CHICAGO, IL 60640 PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES FREGULATORY OR LSC IDENTIFYING INFORMATION) SERGULATORY OR LSC IDENTIFY INFORMATION SERGULATORY OR LSC INFORMATION SERGULATORY OR LSC IDENTIFY INFORMATION SERGULATORY OR LSC INFORMATION SERGULATORY OR LSC INFORMATION SERGULATORY OR LSC INFORMATION SERGULATOR	MADO HE	ALTHOADE LIDTOWN	4621 NOR	TH RACINE AV	ENUE		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) S9999 Continued From page 3 goes to store it falls on (V5) to take him. (V11- PRSC) is now assigned to 4th floor and (V5) continues to still go with (R1) to the store and it is also (V5) who would bring the whole manila envelope back to me. I did not check to make sure everything is in the wallet when the manila envelope was returned to me and when I gave it to (V5), Idd not show (V5) what was in the wallet lake to avoid any theft, honestly to avoid theft of residents' items. I never took (R1)'s wallet and made ATM withdrawals. It is possible the debit card was not in the wallet when it was returned to me because I did not check the contents of (R1)'s wallet. On 09/04/2024 at 3:22pm, this surveyor showed V5 (PRSC Psychiatric Rehabilitation Services Coordinator) R1's Release of Responsibility For Leave Of Absence Forms, dated 02/2024 to 08/2024, and inquired if (V5) recognized the signature/staff on the space provided for PATIENT OR NEAREST RELATIVE. V5 stated "that's me." This surveyor requested V5 to review the PRSC notes on 03/07/2024. V5 stated these (Items) are something that we (V5 and R1) got from R**. We (V5 and R1) got from R**. We (V5 and R1) even to under the was to big or not his style. I can't recall how many were returned. On 09/04/2024 at 3:35pm, V5 stated (R1) made withdrawals mostly at (R1's bank). I never recall any withdrawals outside of (R1's bank). I sloways keep an eye on (R1) because he did not have a steady gait and I don't want (R1) to fall. When I went out with (R1), there was never a time (R1) withdrew money from outside of (R1's bank). I	IVIADO RE	ALTHOARE - UPTOWN	CHICAGO	, IL 60640			
goes to store it falls on (V5) to take him. (V11-PRSC) is now assigned to 4th floor and (V5) continues to still go with (R1) to the store and it is also (V5) who would bring the whole manila envelope back to me. I did not check to make sure everything is in the wallet when the manila envelope was returned to me and when I gave it to (V5), I did not show (V5) what was in the wallet. I should have made a binder, so they sign what they take to avoid any theft, honestly to avoid theft of residents' items. I never took (R1)'s wallet and made ATM withdrawals. It is possible the debit card was not in the wallet when it was returned to me because I did not check the contents of (R1)'s wallet. On 09/04/2024 at 3:22pm, this surveyor showed V5 (PRSC Psychiatric Rehabilitation Services Coordinator) R1's Release of Responsibility For Leave Of Absence Forms, dated 02/2024 to 08/2024, and inquired if (V5) recognized the signature/staff on the space provided for PATIENT OR NEAREST RELATIVE. V5 stated "that's me." This surveyor requested V5 to review the PRSC notes on 03/07/2024. V5 stated these (items) are something that we (V5 and R1) got from R***. We (V5 and R1) yent out on that day. Some of them were returned because it was too big or not his style. I can't recall how many were returned. On 09/04/2024 at 3:35pm, V5 stated (R1) made withdrawals mostly at (R1's bank). I never recall any withdrawals outside of (R1's bank). I laways keep an eye on (R1) because he did not have a steady gait and I don't want (R1) to fall. When I went out with (R1), there was never a time (R1) withdrew money from outside (R1's bank). I	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	COMPLETE
	\$9999	goes to store it falls o PRSC) is now assign continues to still go w also (V5) who would be envelope back to me. sure everything is in the envelope was returned to (V5), I did not show wallet. I should have the what they take to avoid theft of resident wallet and made ATM the debit card was not returned to me becaute contents of (R1)'s wallet and made at the debit card was not returned to me becaute contents of (R1)'s wallet and made at the debit card was not returned to me becaute contents of (R1)'s wallet and made at the debit card was not returned to me becaute contents of (R1)'s wallet and some of them contents of (R1)'s wallet and inquired signature/staff on the PATIENT OR NEARE "that's me." This survetthe PRSC notes on 0 (items) are something from R***. We (V5 and Some of them were rebig or not his style. I determined. On 09/04/2024 at 3:3 withdrawals mostly at any withdrawals mostly at any withdrawals outsit keep an eye on (R1) steady gait and I don't went out with (R1), the withdrew money from	ith (R1) to the store and it is bring the whole manila. I did not check to make the wallet when the manila and to me and when I gave it works (V5) what was in the made a binder, so they sign id any theft, honestly to as items. I never took (R1)'s withdrawals. It is possible at in the wallet when it was se I did not check the lilet. 2pm, this surveyor showed as Rehabilitation Services lease of Responsibility For orms, dated 02/2024 to a fi (V5) recognized the space provided for as RELATIVE. V5 stated these as that we (V5 and R1) got d R1) went out on that day. Seturned because it was too can't recall how many were specially because he did not have a to want (R1) to fall. When I ere was never a time (R1) outside of (R1's bank). I	S9999			

Illinois Department of Public Health

STATE FORM 5899 Z40211 If continuation sheet 4 of 20

Illinois Department of Public Health

IL6009013 B. WING	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER MADO HEALTHCARE - UPTOWN CHICAGO, IL 60640 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG TAG COMMERT REGULATORY OR LSC IDENTIFYING INFORMATION) Summary STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG COMMERTE DEFICIENCY REGULATORY OR LSC IDENTIFYING INFORMATION) S9999 Continued From page 4 wallet, then inside the manila envelope. I don't know how much (R1) takes from the ATM. This surveyor showed V5 R1's bank statement and pointed out to V5 the transaction that was done on 03/07/2024 at (non R1's Bank) ATM withdrawal in the amount of \$244.80 and asked if (V5) could explain the transaction. V5 stated I have no explanation for that, I don't know. This surveyor inquired if V5 has knowingly purchased any items using R1's debit card. V5 stated No. This surveyor inquired if the threatened a resident to get what he needed from the resident. V5 stated I am a very nice guy. R1's Admission Record documented that R1's diagnoses include but not limited to bipolar disorder, essential hypertension, and depression. R1's untitled (complaint) form, dated 03/25/2024, documented, in part "Person sharing the concern:			II 6009013	B. WING		1	
MADO HEALTHCARE - UPTOWN CHICAGO, IL 60640 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH ODERICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) S9999 Continued From page 4 wallet, then inside the manila envelope. I don't know how much (R1) takes from the ATM. This surveyor showed V5 R1's bank statement and pointed out to V5 the transaction that was done on 03/07/2024 at (non R1's Bank) ATM withdrawal in the amount of \$244.80 and asked if (V5) could explain the transaction. V5 stated I have no explanation for that, I don't know. This surveyor inquired if V5 has knowingly purchased any items using R1's debit card. V5 stated No. This surveyor inquired if he threatened a resident to get what he needed from the resident. V5 stated I am a very nice guy. R1's Admission Record documented that R1's diagnoses include but not limited to bipolar disorder, essential hypertension, and depression. R1's untitled (complaint) form, dated 03/25/2024, documented, in part "Person sharing the concern:	NAME OF P	ROVIDER OR SUPPLIER		RESS CITY STA	TE ZIP CODE	1 03/2	.5/2024
CHICAGO, IL 60640 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) S9999 Continued From page 4 wallet, then inside the manila envelope. I don't know how much (R1) takes from the ATM. This surveyor showed V5 R1's bank statement and pointed out to V5 the transaction that was done on 03/07/2024 at (non R1's Bank) ATM withdrawal in the amount of \$244.80 and asked if (V5) could explain the transaction. V5 stated I have no explanation for that, I don't know. This surveyor inquired if V5 has knowingly purchased any items using R1's debit card. V5 stated No. This surveyor inquired if he threatened a resident to get what he needed from the resident. V5 stated I am a very nice guy. R1's Admission Record documented that R1's diagnoses include but not limited to bipolar disorder, essential hypertension, and depression. R1's untitled (complaint) form, dated 03/25/2024, documented, in part "Person sharing the concern:							
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wallet, then inside the manila envelope. I don't know how much (R1) takes from the ATM. This surveyor showed V5 R1's bank statement and pointed out to V5 the transaction that was done on 03/07/2024 at (non R1's Bank) ATM withdrawal in the amount of \$244.80 and asked if (V5) could explain the transaction. V5 stated I have no explanation for that, I don't know. This surveyor inquired if V5 has knowingly purchased any items using R1's debit card. V5 stated No. This surveyor inquired if he threatened a resident to get what he needed from the resident. V5 stated I am a very nice guy. R1's Admission Record documented that R1's diagnoses include but not limited to bipolar disorder, essential hypertension, and depression. R1's untitled (complaint) form, dated 03/25/2024, documented, in part "Person sharing the concern:	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETE
description of the concern: (R1)'s bank account has some unexplain(ed) activity. Description of investigation: Bank was called (to) investigate and replace(d) most of the funding." R1's State Initial Reportable, dated 09/03/2024, documented, in part "It was reported by state surveyor that resident's family member reported unusual activity on bank account." R1's State Final Reportable, dated 09/09/2024, documented, in part "Investigation revealed that electronic payment method/debit card was used for what appear to be unauthorized charges." R1's A***** Order Details, dated 03/06/2024, documented, in part "Shipping Address. (V5 and non-facility address) Payment method. (R1)'s	\$9999	wallet, then inside the know how much (R1) surveyor showed V5 I pointed out to V5 the on 03/07/2024 at (nor withdrawal in the amo (V5) could explain the have no explanation f surveyor inquired if Vi any items using R1's This surveyor inquired to get what he needed stated I am a very nick R1's Admission Recordiagnoses include buildisorder, essential hy R1's untitled (complaid documented, in part "(V14, R1's family mer description of the conhas some unexplain(einvestigation: Bank with replace(d) most of the R1's State Initial Report of the conhas in part "surveyor that resident unusual activity on bath R1's State Final Report of the conhas in part "electronic payment mer for what appear to be R1's A***** Order Det documented, in part "	e manila envelope. I don't takes from the ATM. This R1's bank statement and transaction that was done in R1's Bank) ATM bunt of \$244.80 and asked if transaction. V5 stated I for that, I don't know. This 5 has knowingly purchased debit card. V5 stated No. do if he threatened a resident dofrom the resident. V5 the guy. In documented that R1's to not limited to bipolar epertension, and depression. Intity form, dated 03/25/2024, Person sharing the concerning the concer	S9999			

Illinois Department of Public Health

STATE FORM 8899 Z40211 If continuation sheet 5 of 20

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		IL6009013	B. WING		09	C 0/23/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
MADO HE	ALTHCARE - UPTOWN	4621 NO	RTH RACINE AVE	NUE		
WIADO IIL	ALTIOAKE - OF TOWN	CHICAG	O, IL 60640			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
S9999	Continued From page	÷ 5	S9999			
	numbers)." Of note, s the facility.	hipping address was not of				
	stated not sure if R1 I PRSC's ordering for r address should be the the PRSC address. W address if we are ope expectation is everyth this building (facility).	tion Services Director) has an A***** account. esidents online, the shipping e facility's address and not //hy ship stuff to the PRSC				
	Rehabilitation Service sure (R1) has no A***	es Director) stated I know for ** account. (R1) is not that ed to use the smart phone				
	documenting "PIN # (R1's Bank statement, 03/26/2024, document Deposit and Addition: 03/07 Purchase Return in the amount of \$252 3/14 ATM Cash depositions 3/19 Card Purchase Fidigits) in the amount of	d with a handwritten note 4-digit number)." dated 02/28/2024 - ited the following, in part. " irns (bank card last 4 digits) 2.29 sit in the amount of \$400.00. Return (bank card last 4 of \$15.24 tore) in the amount of				
	last 4 digits) with a tot 2. (2x) ATM Withdraw with a total amount of	ATM withdrawals (bank card tal amount of \$2,881.05. rals (bank card last 4 digits)				

Illinois Department of Public Health

STATE FORM 5899 Z40211 If continuation sheet 6 of 20

Illinois Department of Public Health

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:			COMPL	
					<u> </u>	3
		IL6009013	B. WING			23/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE. ZIP CODE	•	
			RTH RACINE AV			
MADO HE	ALTHCARE - UPTOWN		D, IL 60640			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU	JLD BE	COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE	DATE
S9999	99 Continued From page 6		S9999			
	03/14/24, and 03/18/2	24 (bank card last 4 digits)				
	with a total amount of	f \$367.44.				
	4. (2x) W***** purcha	ases (bank card last 4 digits)				
	with a total amount of					
		ases (bank card last 4 digits)				
	with a total amount of	·				
	last 4 digits) with a to	se + cash back (bank card				
		uses (bank card last 4 digits)				
	with a total amount of					
	8. (1x) Card purchase	with pin (Pet Store) (bank				
	card last 4 digits) in the	ne amount of \$119.06.				
		ount of purchases and				
	withdrawals without re	•				
		nk card last 4 digits) with				
	receipts provided by tamount of \$4,483.60.	•				
	amount or ψ4,400.00.					
	The (09/06/2024) em	ail correspondence with V1				
	,	quiry of this surveyor "Do you				
		ots for (R1) aside from the				
		024 R*** Receipts; 3/7/24				
		receipt; 03/11/24 (x2) E**				
		CEIPTS; 03/07/24 (x2) and pts?" V1 wrote in response				
	"No I gave you every					
	ito i gavo you overy	amig we have.				
	On 09/17/2024 1:18p	m, V15 (PRSD (Psychiatric				
		es Director) stated (R1) has				
	no car and has no pe	t.				
	The D*** ' ' ' '	4 00/07/0004 -+ 40:40				
		d 03/07/2024 at 10:46am,				
		items. The R*** receipt 1:52pm, documents 16				
	returned items. The F					
		n, documents 6 sold items.				
	Of note, 9 items were					
		(Patient's Clothes and				
	Personal Belongings)	list, dated 03/12/2024,				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
ANDIEAN	or contribution	IDENTIFICATION NOMBER.	A. BUILDING: _			
		IL6009013	B. WING		09/2	3/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MADO HE	ALTHCARE - UPTOWN	4621 NOR CHICAGO,	TH RACINE AV IL 60640	ENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
\$9999	Shoes x 2 and 1 mag items were missing. R1's Personal Belong documented in part "2 note, no additional be and before 09/05/202 facility to this surveyor. The Daily Staffing dat 03/14/24, and 03/18/2 (Administrator Assistat (Security/Front Desk) and V21 (Security/Frodays either the 8am - shift or 12am - 8am signary of the shift of 27 years as security of the shift of 27 years as security of the shift of 27 years as security of the shift	Clothing Retained by Patient: ic shine sponge." Of note, 6 ging list, dated 09/05/2024, 2 trousers and 1 Polo." Of clonging list after 03/12/2024 4 was provided by the r. Sed 03/10/24, 03/12/24, 24, documented that V12 ant/Front Desk), V19, V20 (Security/Front Desk) ont Desk) worked on these 4pm shift or the 4pm-12pm hift. 9am, V12 stated I started in Monday thru Friday, job is to call up the floor or pick up food order. I never e calling (R1) to pick up his 57am, V19 (Security/Front een working at the facility ity or front desk staff. I work apm, 4pm-12am, and allow (R1). I never received from G*****b for (R1). 3pm, V22 (Security/Front here in 2021 or 2022. I am ever received any food order ****** packages for him (R1).	S9999			
		ever received any online *** packages for (R1).				

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Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6009013	B. WING		C 09/23/2024
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	, 00/20/2021
MADO HE	ALTHCARE - UPTOWN	4621 NORT CHICAGO,	H RACINE AV IL 60640	ENUE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
S9999	Continued From page 8		S9999		
	On 09/03/2024 at 3:34pm, V1 (Administrator) stated I called (V14 - R1's family member). V14 said it would take the bank 8-10 weeks before he could hear from them. I would be mad if I were not able to touch my money for that long. On 09/05/2024 at 11:54am, V1 (Administrator) stated no one should be stealing the resident's money. I am the Administrator; I have the key to (V4)'s office. There was never a time I took (R1)'s wallet from (V4)'s office. I spoke with him (V14 - R1's family member) and he said he will not hear from the bank for 8-10 weeks. This surveyor inquired how would V1 feel not having access to her money in the bank for 8-10 weeks. V1 stated, I would be mad. On 09/05/2024 at 12:02pm, reading the charges on R1's March 2024 bank statement, this surveyor inquired if V1 could explain the withdrawals in the statement, V1 stated I cannot explain them.				
	stated I hired an outsi	on the situation, on anything			
	(Private Investigator's	27am, V25 (President - c) Group) stated they (V1) c office, and they saw (R1)'s a PIN written on it.			
	stated I have to searched up searching h	8pm, V1 (Administrator) th (V5)'s office regardless. I sis whole office. There was a I. I know it is a PIN number PIN written on it.			

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Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		IL6009013	B. WING		09	C / 23/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
MADO HE	ALTHCARE - UPTOWN	4621 NO	RTH RACINE AVE	NUE		
- INABOTIL	ALTHOAKE - OF TOTAL	CHICAG	O, IL 60640			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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
S9999	Continued From page	9	S9999			
	The (09/18/2024) emic (Administrator) documilist of residents' items (R1) Assurance wireled dating January 27th to 2. On 09/16/2024 at 1 (Private Investigator's resident (R6) gave her he will take care of the control	ail correspondence with V1 nented, in part "Here is the retrieved from (V5)'s office. ess notice, bank statement hru February 27th." 11:27am, V25 (President- s) Group) stated another er debit card to (V5) who told of her finances for her. 8pm, R6 stated I have about urd. I gave my bank card to ember of last year. (V5) is d in case I need something id not tell me I could have and I will take care of your new I have a bank card need stuff from the store, I ank card. I never received ere because I don't want my finances. I called the said I have a dollar in my quired how R6 felt about her d having a dollar in her (R6) am so pissed I can pee." It I; (V5) took all my money. d who was sending money a pension every month. I ecc of paper and handed it Opm, V15 stated I have but (R6) is not going to say or from time to time (V5)				
		to buy wnatever (R6) needs. When I asked have access to your card?"				
	, , ,	as access and he knows the				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		IL6009013	B. WING		C 09/23/2024
					03/23/2024
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA		
MADO HE	ALTHCARE - UPTOWN		TH RACINE AV	ENUE	
		CHICAGO	IL 60640		
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
S9999	Continued From page	e 10	S9999		
	pin to the card. I asket because (V5) is going for me. At that point, I going down to (V1)'s made (V1) aware of the (R6)'s bank. We (V1, card and we asked for statements. I asked for Most of them occurrens shocked because she 09/03. The customer some of the transaction mobile payment applit transactions of \$200. doing it, is just cleaning the bank account. The transactions. (R6) saif those transactions. We this, she was so shoot my God! Oh, my God expected of PRSC or card with them without was trying to help (R6).				
	received (R6)'s bank	9pm, V15 stated we just statement. V15 showed this			
		ions on R6's (07/2024- nt. V15 stated (R6) has			
		3. On the same day (09/03)			
		Person to Person mobile			
	. ,	transactions to K****h			
		/1), K****h is (V5's) middle			
	name. There were 9 t	ransactions on 9/03 and 1			
		(R6) will not make those			
		she had not realized that			
		et on the 09/03. Obviously,			
	(R6) is getting \$750 a month. I don't think (F	it the beginning of the R6) has (Online Music			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		IL6009013	B. WING		09	C 9/ 23/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
MADO HE	EALTHCARE - UPTOWN		ORTH RACINE AVEN	NUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ID PROVIDER'S PLAN OF CORRECTION (REFIX (EACH CORRECTIVE ACTION SHOULD BE COM		
\$9999	Streaming Service). app for music. I can ghave a (Online Music R6's Bank statement documented, in part benefit payment depother debits: 7/01- (Oservice) \$10.99. Che Detail: ending balance R6's Bank statement documented, in part benefit payment depother debits: 8/01 - A8/08 (Online Music SChecking account Subalance: \$60.13. R6's (09/10/24) bank part "Deposits and credeposit - \$750. Chec Cash App * K***** h Cto Person mobile pay C**** \$80.00. 9/03 (Ppayment application) (Person to Person mok**** \$200.00 Service Subscription) Summary and Detail: R6 Admission Record diagnoses include buobstructive pulmonar unspecified dementia without behavioral dis disturbance, mood di	That is an online streaming guarantee you, (R6) did not Streaming Service). dated 07/10/24, Deposits and credits: 7/01 posit - \$750. Checks and online Music Streaming cking account Summary and e: \$65.29. dated 08/09/24, Deposits and credits: 8/01 posit - \$750. Checks and TM W/D Card # \$408.00. treaming Service) - \$11.99. Immary and Detail: ending statement documented, in edits: 9/03 benefit payment ks and other debits: 9/03 posit - \$15.00. 9/03 (Person ment application), K***** + \$15.00. 9/03 (Person ment application), Comment application), Desire payment application, Desire payment applicati	S9999			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
		IL6009013	B. WING		09	C 0/23/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
MADO HE	ALTHCARE - UPTOWN		RTH RACINE AVEN	NUE		
			O, IL 60640			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
S9999	Continued From page	e 12	S9999			
	Interview for mental sindicating R6's mental sindicating R6's mental sindicating R6's mental sindicating R6's GG017 with two turns: 88 - not condition or safety condition or safety condition or safety condocumented, in part bank card is missing. R6's State Final report documented, in part to an incident that occar resident (R6) report missing. (R6) stated I bank card) was (V5). electronic payment missing.	Section C0500. BIMS (Brief status) Summary Score: 14." all status as cognitively intact. O. Mobility. J. Walk 50 feet of attempted due to medical neerns." rtable dated 09/10/2024, Resident reported that her				
	9:16, documented, in a history of frivolous i	note dated 12/25/2023 at part "Resident present with money management. PRSC on setting goals to handle ssible investing."				
	part "Resident is at in experienced financial psychological and/or free of any financial a					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7 BOILBING.	BUILDING.		
		IL6009013	B. WING		C 09/23/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
	ALTUGADE UDTOWN	4621 NOF	TH RACINE AV	ENUE		
MADO HE	ALTHCARE - UPTOWN	CHICAGO), IL 60640			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETE	
S9999	Continued From page	: 13	S9999			
59999	(monetary/kinds/good not have a policy, what V1 wrote in response it is said that no person with the facility will accompensation from an The CNA Supervisor J4/21/23, documented, Resident Belonging is and as needed and up The PRSC (Psychiatr Coordinator) Job Desidocumented, in part our organization's goathe Guests we serve, the overall administrate evaluation of the social and maintain the men well-being for (of) each Functions: Reasonab made to enable indiviperform the essential the inspection of guest they are properly laber The Front desk/Security stagreeting, welcoming, appropriately; notifies visitor arrival; maintain telecommunications is Responsibilities: 5. Mideparture of employers	is) from residents? If you do at are your expectations?" "In our employee handbook onnel or persons associated cept gifts of money or goods ors remuneration or other my client." job Description dated in part "Ensure that is completed upon admission or to date." ic Rehabilitation Services cription (Undated) Summary: In keeping with all of improving the lives of the PRSC is responsible for tion, coordination, and all services function to meet that and psychosocial the Guest. Essential le accommodations may be duals with disabilities to functions. 4. Coordinates its belongings to ensure eled and inventoried." irity Job Description dated ed, in part "Summary: The aff attend to visitors by and directing them company personnel of ins security and system. Essential	29999			
	the log-in and log-out					

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		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		7. BOILDING.		С	
П	L6009013	B. WING		09/23/2024	
NAME OF PROVIDER OR SUPPLIER	STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
MADO HEALTHCARE - UPTOWN		H RACINE AV	ENUE		
	CHICAGO, I				
(X4) ID SUMMARY STATEMENT PREFIX (EACH DEFICIENCY MUST BI TAG REGULATORY OR LSC IDENT	E PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
S9999 Continued From page 14		S9999			
The Personal Property Policy dated 01/24/2024-4163, documented the policy of the (Facility) to pretain personal property items not infringe upon the rights of affect the safety and well-bein Procedure. 5. The belonging as needed upon receiving new The Signing Patients Out Whe Building policy dated 01/01/2 part "Intent: Signing patients taking residents out of the but This policy ensures that where taken out of the building by a staff member is to sign the patient front desk with a date and the front desk with a date and the front desk with a date and the facility are done proper any (Facility) Healthcare policy staff orders items online for the are to be shipped and received The Abuse Policy dated 1/4/2 part "It is the policy of the facility are done proper and the facility are done proper and the facility of the facility of the facility are done proper and the facility of the facility are done proper and the facility of the facility are done proper and the facility of the facility. No abuse or harm tolerated."	umented, in part "It is permit residents to a salong as they do fother residents or ang of the residents. Its shall be updated witem." Item Leaving the 024, documented, in out when staff are idding. Procedure: In any resident is staff member, that atient in and out at ditime." Items policy dated part "This policy or residents by staff rely and complies with cies. Procedure: If the residents, they ged to the facility." 24, documented, in idlity that each is see. Abuse can resident property and idents will be they are residing at				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CO			E SURVEY PLETED
		IL6009013	B. WING		09	C 9/23/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE	•	
MADO HE	ALTHCARE - UPTOWN		ORTH RACINE AVE	NUE		
	T		GO, IL 60640			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
S9999	Continued From page	÷ 15	S9999			
	Statement of Licensu	re Violations (2 of 2)				
	300.661					
	Section 300.661 Hea Background Check	alth Care Worker				
	A facility shall comply Worker Background (Care Worker Backgro	Check Act and the Health				
	This requirement is n	ot met as evidenced by:				
	Based on interview and record review, the facility failed to follow their own policy to conduct a complete background check of employees prior to working with residents. This failure has the potential to affect all the residents at the facility.					
	Findings include:					
	07/31/2023, V7 (CNA 04/01/2024, V8 (Certi hired on 06/27/2024,	nat V5 (PRSC) was hired on Supervisor) was hired on fied Nursing Assistant) was V9 (CNA) was hired on A) was hired on 04/30/2024,				
	(Administrator) docum 3rd floor, V7 works or any floor, V9 works o	ail correspondence with V1 nented that V5 works on the n all the floors, V8 works on n the 2nd and 3rd floor, V10 r, and V11 works on the 4th				
		33am, V4 (Office) stated the purpose of the ckground check is to see if				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: C C	ILD
IL6009013 B. WING 09/23/2	3/2024
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
MADO HEALTHCARE - UPTOWN 4621 NORTH RACINE AVENUE	
CHICAGO, IL 60640	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCY PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CORRECTIVE ACTION SHOULD BE CORSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999 Continued From page 16 staff are eligible to work in a nursing home facility. To make sure the correct kind of people with good character are working here at the facility to prevent abuse. When applicants come to fill out the application form, I (V4) do the background check. Our policy is to do it after I (V4) received the application. Before hiring, to know if they are eligible or not, to work at the facility to prevent abuse to our residents. If they are hired today, healthcare background should be done today. Applicants can't be hired until background check is in good standing. On 09/04/2024 from 10:35am -10:50am, during the review of V5, V7, V8, V9, V10, and V11 personnel file, this surveyor inquired for the result of V5's, V7's, V8's, V9's, V10's, and V11's Illinois Sex Offender, Department of Corrections Wanted Fugitive, and Health and Human Services Office of Inspector General registries. V4 stated I (V4) don't have them. When I (V4) got the position, I (V4) was taught to check in IDPH worker registry. I (V4) was not taught to check in IDPH worker registry. I (V4) was not taught to check melpoyees on those registries that you mentioned. I (V4) am not completely checking the background of the employees and it put residents at risk to anything that the staff may have on their background that I (V4) don't know of because I (V4) did not check staff on those registries. Review of V5's personnel file indicated that background check was initiated on 09/03/2024. Of note, no results provided for Illinois Sex Offender, Department of Corrections Sex Offender, Department of	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
						С
		IL6009013	B. WING		09	/23/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
MADO HE	ALTHCARE - UPTOWN	4621 NC	ORTH RACINE AVE	NUE		
WIADO HE	ALTHORNE - OF TOWN	CHICAG	O, IL 60640			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
S9999	Continued From page	÷ 17	S9999			
	background check wa Of note, no results pro Offender, Department Offender, Department Search, Department of Fugitive, and Health a of Inspector General in Review of V8's person background check wa Of note, no results pro Offender, Department Offender, Department Search, Department	t of Corrections Sex t of Corrections Inmate of Corrections Wanted and Human Services Office registries. Innel file indicated that as initiated on 06/27/2024. Divided for Illinois Sex t of Corrections Sex t of Corrections Inmate of Corrections Wanted and Human Services Office				
	background check wa Of note, no results pro Offender, Department Offender, Department Search, Department of Fugitive, and Health a of Inspector General in Review of V10's person	t of Corrections Sex t of Corrections Inmate of Corrections Wanted and Human Services Office registries. onnel file indicated that as initiated on 03/26/2024.				
	Offender, Department Offender, Department Search, Department of Fugitive, and Health a of Inspector General in Review of V11's person	t of Corrections Sex t of Corrections Inmate of Corrections Wanted and Human Services Office				
	_	e to printing. Of note, no				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:				
					С		
		IL6009013	B. WING		09/23/2024		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	F ZIP CODE			
	4621 NORTH RACINE AVENUE						
MADO HE	ALTHCARE - UPTOWN		O, IL 60640				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLÉTE		
S9999	Continued From page results provided for III Department of Correct Department of Correct Department of Correct Health and Human Se General registries. The (undated) Busine Specialist documente office manager/payrol as the first line of assist the facility; supporting heads and employees monitoring and procesincluding: maintains e Completes backgroun. The (1/4/24) Abuse Pis the policy of the facility of the facility. No abuse the facility. No abuse the facility. No abuse tolerated. Overview of Screening. Abuse policy of this facility to working with residents include criminal backgemployee screening anot hire an employee abuse, exploitation care.	inois Sex Offender, stions Sex Offender, stions Inmate Search, stions Wanted Fugitive, and ervices Office of Inspector as Office Manager/Payroll d, in part "As business as I specialist you will operate stance to employee within a operations, department as alike. Responsible for assing facility payroll, employee personnel files. Indicate checks. Colicy documented, in part "It is that each resident will abuse can include asident property and ally, residents will be while they are residing at or harm of any type will be a Seven Components. A. icy requirements: it is the a screen employees prior to be screen employees prior to be screen ing components ground check. Procedure: 1. and training. The facility will who was found guilty of all mom or misappropriation	\$9999		RIATE DATE		
	in the state nurse aid exploitation, or misap property. For prospec documentation of stat actions from other reg facility will not employ	of law; or who has a finding registry concerning abuse, propriation of resident tive employees, reviewing us and any disciplinary gistries. A. Nurse aides: the an individual who has a state nurse aid registry					

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Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6009013	B. WING		C 09/23/2024	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						<u> </u>
MADO HE	ALTHCARE - UPTOWN	4621 NORT CHICAGO,	H RACINE AV IL 60640	ENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
S9999	concerning abuse, ex misappropriation of re criminal background of all prospective emplo		\$9999			

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