STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009013	A. BUILDING: _____ B. WING _____	C 01/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADO HEALTHCARE - UPTOWN	4621 NORTH RACINE AVENUE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Facility Reported Incident of 12/04/2024 /IL00182368	S 000		
S9999	Final Observations Statement of Licensure violation: 300.690a) 300.690b) 300.690c) Section 300.690 - Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. This REQUIREMENT is not met as evidenced by: Based on review of records and interviews the facility failed to report serious incident or accident within the required time frame to State Agency for 1 out of 1 resident (R1). This failure impede	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009013	A. BUILDING: _____ B. WING _____	C 01/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADO HEALTHCARE - UPTOWN	4621 NORTH RACINE AVENUE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 1	S9999		

accurate determination of fall incidents related to R1.

Findings include:

R1 is 70 years old, a resident in the facility since 10/08/2020. R1 has moderate impairment of cognition based on brief interview of mental status (BIMS) dated 10/15/2024 with a score of 12. R1 was not in the facility during review, per V10 (Registered Nurse) nursing notes dated 12/28/2024. R1 was transferred to the hospital due to vomiting.

On 12/31/2024 at 11:21 AM. V8 (Licensed Practical Nurse) stated that R1 used to be the current floor that working currently. And was admitted on a different floor after hospitalization. V8 stated that R1 underwent hip surgery. And was ambulating without any help before the fall. V8 cannot remember if R1 was using any device like walker when ambulating.

R1's notes related to the incident are documented as follows:

V3 (Licensed Practical Nurse) nursing notes dated 11/28/2024, documents that R1 was noted limping while ambulating in the hallway. V5 (Medical Doctor) was informed and ordered an X-Ray to the right hip to pelvic area.

V5 (Medical Doctor) medical notes dated 12/02/2024, documents that R1 has pain in the right hip. R1 does not know what happened but think that she fell. V5 noted right leg showing extended and rotated. V5 documents that he suspects right hip fractures upon examination although portable X-Ray does not indicate fracture or dislocation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009013	A. BUILDING: _____ B. WING _____	C 01/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADO HEALTHCARE - UPTOWN	4621 NORTH RACINE AVENUE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 2	S9999		

V6 (Licensed Practical Nurse) nursing notes dated 12/02/2024, documents that R1 was scheduled to be transferred to the hospital. And V7 (Registered Nurse) nursing notes dated 12/02/2024 documents that hospital nurse called informing her that R1 has been admitted with closed right hip fracture that needs surgery.

On 01/02/2025 at 09:57 AM V2 (Director of Nursing) stated that a nurse tried to tell her that R1 was supposed to use the walker but did not and got up. When asked who was the nurse that told her? V2 said that she was not sure. And that she may have mixed R1 from other residents. After reviewing R1's printed progress notes. V2 said (reading the notes), "On 11/28/2024 she (R1) was limping when ambulating in the hallway. Yes, she (R1) was allowed to ambulate." V2 was asked about the current status of R1 after the incident? V2 stated that R1 is now chair or bed bound when R1 came back from the hospital after the incident. V2 was asked why State agency was informed on 12/06/2024 when nursing notes of R1 documents that V7 (Registered Nurse) was informed by the hospital that R1 sustained a right hip/pelvis fracture that needs surgery? V2 stated that notification to the State Agency need to be done within 24 hours. And that she only knew that R1 was verbalizing that she fell when the hospital called and informed her that R1 said she fell here in the facility. V2 was made aware that per V5 (Medical Doctor) physician notes dated 12/02/2024, it was documented that R1 verbalized to V5 that she may have fall. V2 said, "I was not aware that R1 verbalized to V5 that she (R1) may have fall."

Per Incident Report of the facility related to R1 fall incident by V2, documents as follows:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009013	A. BUILDING: _____ B. WING _____	C 01/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADO HEALTHCARE - UPTOWN	4621 NORTH RACINE AVENUE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 3 During R1's admission to the hospital (12/02/2024), the facility received a call from the hospital that R1 will be undergoing right hip surgery due to fracture and that the R1 said she fell in the facility. Although facility knew about R1's fracture and fall incident via hospital communication. Facility sent a initial report to the State agency via email on 12/06/2024 or four (4) days after R1's right hip fracture was communicated by the hospital. (C)	S9999		