Illinois Department of Public Health

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 08/26/2019

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 Complaint 1986082/IL114976 investigation	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)6) 300.3240a) 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 300.1210 General Requirements for Nursing and Personal Care 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 care and personal care shall be provided to each	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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 08/26/2019

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		

resident to meet the total nursing and personal care needs of the resident.

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:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These Regulations were not me as evidence by:

Based on interview and record review the facility failed to prevent the physical abuse of 1 of 3 residents (R1) who were reviewed for abuse in a sample of 10. This failure resulted in R1, while attempting to flee from V4 (receptionist/security) abusive behavior, falling and sustaining a fracture to the right arm/shoulder.

Findings include:

According to the face sheet, R1 is diagnosed with including Dementia with behavioral Disturbance. R1 has difficulties with communication (speaks Polish) and self expression. R1 is socially isolative.

8/21/19 2PM V2 (Director of Nursing) stated R1

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 08/26/2019

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		

was chased by the receptionist with a broom upsetting resident who picked up a dust pan that was on the floor, and started chasing the receptionist. This is when R1 slipped and fell. Facility's video was observed and an abuse investigation was conducted. The incident was substantiated. The receptionist/security (V4) was fired. This was reported to Illinois Department Of Public Health.

Review of accident/incident report dated 8/13/19 states that at 1:00 AM R1 reported to staff that the lady hit him in the head with a brush. R1 reported right shoulder pain. 4:15PM R1 was sent to hospital and diagnosed with a right shoulder fracture. Police report was filed with the local police department.

2nd incident report dated 8/13/19 states Certified Nurse Aid Supervisor (V5) came to Director of Nursing (V2) approximately 1:30PM to say that R1 reported to her " she hit me with a brush. V2 proceeded to review cameras. There was a physical altercation between V4 and R1. R1 was sent to the hospital. During further review of camera and investigation , V4 was observed with a broom and hit resident with bristle side of the broom in face to have him leave the dining room. R1 was trying to get away from her as she raised the broom, now in hallway, resident fell. Administrator (V1) and office manager (V6) also viewed the camera . R1 was sent to the hospital . V4 was called by V1 and immediately terminated.

Review of hospital emergency room record dated 8/13/19 reveals R1 sustained a right syncope humeral (arm/shoulder) fracture. R1 remains in the hospital.

Facility policy titled Abuse Prevention Program

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 08/26/2019

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 dated 8/19 includes statement the resident has the right to be free of abuse. (A)	S9999		