STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0049924	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBASSADOR NURSING & REHAB CENTER	4900 NORTH BERNARD , CHICAGO, Illinois, 60625

(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) COMPLETION DATE
S0000	Initial Comments Complaint Investigation 2586435/IL2561618	S0000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210d)6) 300.3210t) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive	S9999		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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 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 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These requirements were not met as evidenced by: Based on interview, and record review, the facility failed to provide adequate supervision for a resident (R6) at risk for falls and failed to ensure that a resident (R6) at risk for falls does not have repeated falls and failed to protect one resident (R6) from physical abuse from another resident (R7). These failures affected 1 of 3 residents, reviewed for falls, fall prevention interventions, and abuse. This caused R6 to be sent to the local hospital and R6 sustaining a comminuted left intertrochanteric fracture requiring R6 to have open reduction internal fixation of the left hip fracture. Findings include: R6 has a diagnosis which include but are not limited to: Repeated falls, Alzheimer’s disease, lack of coordination, abnormalities of gait and mobility, weakness, dementia, ataxic gait, unsteadiness on feet,	S9999		

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S9999	Continued from page 2 and insomnia. R6 has a Brief Interview for Mental Status (BIMS) dated 07/10/25 with no score and indicates that R6 has memory impairments. R6 Minimum Data Set (MDS) dated 07/10/25 shows that R6 requires supervision or touching assistance for walking. R7 has a diagnosis which includes but are not limited to: cocaine abuse, disorientation, other disorders of the brain, cerebral infarction, cerebral ischemia, and anxiety. R7 has a Brief Interview for Mental Status (BIMS) dated 04/30/25 with a score of 6 and indicates that R7 has memory impairments. During this survey R7 was able to answer surveyor questions appropriately. The facility Initial Reportable Incident to the state agency dated 07/13/25 at 9:40 am, documents, in part: “R7 allegedly made contact with R6. R6 and R7 immediately separated. Body assessment completed on R7, no injuries or pain. R6 sent to local hospital for an evaluation. Hospital reported R6 sustained left hip fracture due to fall. Physician and family notified. Police was contacted and notified. R7 was placed on one-to-one period. investigation initiated.” R6’s local hospital record dated 07/14/25 documents, in part: “Interval Events: Plan for open reduction internal fixation left hip fracture … Imaging/Other Studies: CT (Computed Tomography) without contrast, left: Results: 07/14/25: Impression: 1: Comminuted left intertrochanteric fracture.” On 07/15/25 at 11:30 am, Surveyors observed V23 (Licensed Practical Nurse, LPN) (R6 and R7’s nurse on 07/13/25) leave the facility via 911 emergency due to V23 not feeling well. On 07/15/25 at 1:07 pm, V12 (R6’s Family Member) stated that on 07/13/25 V12 received a phone call from V23 (LPN) stating that V23 turned away from R6 for one second and R6 was pushed by R7 onto the floor. V12 also explained that V23 informed V12 that R6 was going to the local hospital for an evaluation. V12 stated that the local hospital informed V12 that R6 sustained a left hip fracture. V12 then explained that on 07/14/25 V12 came to the facility and informed V1 (Administrator) at facility that V12 filed a police report number JJ333620 regarding R7 pushing R6 onto the floor causing R6 to sustain a left hip fracture.	S9999		

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S9999	Continued from page 3 On 07/16/25 at 9:31 am, V1 (Administrator) informed surveyors that V23 was a admitted to the local hospital. Surveyor was not able to interview V23 for this investigation. On 07/16/25 at 9:52 am, R7 stated that a few days ago R7 was standing at the elevator when R6 kept approaching R7. R7 stated that R7 told R6 “Get the F*** away from me” and pushed R6 away from R7. R7 explained that R6 landed on the floor after R7 pushed R6. R7 then stated, “I didn’t throw her down. I pushed her.” R7 then reiterated that R7 kept yelling at R6 “Stay away from me” and that R6 didn’t. On 07/16/25 at 10:23 am, V22 (Certified Nursing Assistant, CNA) denied that V22 was assigned to R6 or R7 on 07/13/25 and does not know where V25 (CNA) and V26 (CNA) (who were assigned to R6 and R7) were located on the unit during the time of R6 and R7’s incident. V22 explained that V22 believes that V25 and V26 were down the hallway gathering their belongings to leave for the day. V22 further explained that V22 was at the nurse's station on 07/13/25 during the time of the incident with R6 and R7. V22 then stated that V22 recalls R6 standing in front of R7 at the nurse's station, elevator area when R7 was telling R6 to get out of her (R7’s) face. V22 further explained that R6 kept walking into R7’s face when R7 turned around and put her (R7’s) hand out in front of R6 making contact with R6’s chest causing R6 to fall onto the floor. V22 further explained that V22 was behind the nurse's station when the incident occurred and was gathering her belongings to go home. V22 then explained that by the time she came from around the nurse's station to R6 and R7, R6 was already on the floor. V22 also explained that V23 (Licensed Practical Nurse, LPN) R6 and R7’s assigned nurse was down the third-floor unit hallway still passing medications and that V24 (Registered Nurse, RN) was sitting at the nurse's station charting. V22 explained that V22 and V23 (LPN) assisted R6 off the floor. On 07/17/25 at 9:34 am V24 (Registered Nurse, RN) stated that on 07/13/25 around 6:45 am, V24 was at the nurse’s station charting and not paying attention to R6 and R7 at the third-floor unit elevator area in front of the nurse’s station. V24 explained that V22 (CNA) was informed V24 that R6 sustained a fall at the nurse’s station in front of the elevator. V24 stated that although V24 was at the nurse’s station with R6 when R6 sustained a fall, V24 denies witnessing or hearing R6 sustained a fall or hear any conversation between R6 and R7. V24 explained that V24 was not the	S9999		

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S9999	Continued from page 4 assigned nurse for R7 or R6 and did not assist with R6's fall on 07/13/25. V24 stated that R6 is a resident that ambulates with unsteady gait and requires assistance from staff supervision. V24 explained if a resident who ambulates requires staff supervision to ambulate is not supervised, the resident can sustain a fall, elope, or encounter an argument with another resident. V24 then explained that it is important to monitor and supervise residents who walk with an unsteady gait that are high risk for falls because the resident may need assistance from staff to prevent the resident from falling. On 07/17/25 at 9:48 am V25 (CNA) stated that on 07/13/25 when R6 sustained a fall, V25 was assigned to R6, got R6 dressed around 4:30 am and R6 began walking throughout the unit. V25 explained that R6 is a resident who requires supervision from staff when she walks to prevent R6 from falling. V25 further explained that V25 is instructed to walk with R6 when she is up walking because R6 is a high risk for falls. V25 then explained that during the time of R6's fall on 07/13/25, V25 did not witness R6's fall at the nurse's station in front of the elevator and that V25 was at the nurse's station packing V25 belongings (cell phone and cell phone charger) preparing to go home. V25 explained that V25 heard a sound and observed R6 laying on the floor in front of the elevator at the nurses station and R7 standing next to R6. V25 also explained that R6's nurse was down the third-floor unit hallway preparing her cart/medications when V25 called for R6's nurse after R6 sustained a fall on 07/13/25. V25 explained that V25 and V23 (LPN) assisted R6 off the floor. V25 denies seeing R7 push R6 on 07/13/25 or recalls anything R7 said to R6 on 07/13/25. On 07/17/25 at 10:00 am, V26 (CNA) stated that V26 did not witness R6 fall on 07/13/25. V26 explained that it was the end of V26's shift around 6:45 am and V26 was at the nurses station charting waiting for the next shift of staff to arrive on the unit. V26 stated that V26 was not assigned to R6 or R7 on 07/13/25 during the time of R6 fall incident. V26 explained that V22 (CNA) informed V26 that R7 pushed R6. V26 also stated that V26 heard V23 (LPN) stating to R7 "Why did you do that to R6." V26 further explained that V23 (LPN), V25 (CNA), and V22 (CNA) (who were assigned to R6 and R7) addressed the incident between R6 and R7 on 07/13/25 and that V26 went home. V26 also stated that V26 is familiar and has cared for R6 in the past. V26 stated that R6 ambulates and requires supervision from staff when walking to prevent R6 from falling. On 07/17/25 at 10:35 am, V28 (On Call Physician) (R6	S9999		

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S9999	Continued from page 5 physician on 07/13/25) stated that on 7/13/25 V28 received a call from the facility that staff witnessed R6 falling backwards onto R6's back area and complained of facial grimaces. V28 explained that staff informed V28 that R6 was a resident who walked with an unsteady gait and was roaming the nurses station area when R6 fell. V28 stated that residents who ambulate with and unsteady gait should be placed in a fall supervision program and supervised by staff at all times when walking to avoid the resident from falling and sustaining an injury. V28 further explained that V28 gave orders for R6 to be sent out to the local hospital for an evaluation to rule out fractures. V28 then stated that V28 was informed that R6 sustained a hip fracture due to R6 fall on 07/13/25. When V28 was asked regarding R7's aggressive behaviors, V28 explained that when staff called V28 at the time of R6's fall on 07/13/25, staff at the facility did not inform V28 regarding R7 being involved with R6's fall on 07/13/25 until right before the surveyor spoke with V28 on 07/17/25. V28 stated, "If I was made aware that there was a fight, I would have ordered interventions to address R7's behaviors such as possibly ordering a mood stabilizer, placing R7 on one-to-one monitoring, and sending R7 out to the local hospital for a psychiatric evaluation." On 07/17/25 11:25 am, V2 (Director of Nursing, DON) stated that R6 is an alert, not oriented resident, who wanders throughout the unit, is high risk for falls, has had multiple fall incidents in the past and requires supervision from staff when walking. V2 explained that residents who are high risk for falls can sustain a fall if the resident is not supervised when ambulating and require staff supervision when walking to keep the resident safe. V2 stated that fall interventions in place for R6 include staff placing R6 in a wheelchair after R6 has been ambulating the unit for a while and making sure R6 is hydrated. V2 stated that V2 was not present in the facility during the time of R6 and R7's incident on 07/13/25. V2 stated that V2 was informed by staff that R7 was allegedly seen extending R7's left arm towards R6 during the time of R6's fall on 07/13/25 and that V2 was still investigating the cause of R6's fall on 07/13/25. V2 then explained that V2 instructed staff to call R6's physician regarding R6's fall incident and that R6 physician gave orders to send R6 out on 07/13/25 to the local hospital and was diagnosed with left hip fracture. When V2 was asked regarding the physician's orders/response to R7's behaviors V2 stated that V28 should have been made aware of R7's aggressive behaviors and that V2 was still conducting V2's investigation with R6 and R7's incident on 07/13/25.	S9999		

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S9999	Continued from page 6 On 07/17/25 12:32 pm, V1 (Administrator) stated that V1 is the facility abuse coordinator. V1 explained that staff should report abuse immediately to V1 and that V1 reports allegations of abuse to the local state agency within two hours. V1 explained that on 07/13/25 V1 reported an alleged abuse regarding R6 and R7 that V1 labeled allegation of contact. V1 then explained that if a resident pushes another resident that it is considered physical abuse. V1 further explained that if physical abuse occurs in the facility the facility must protect the alleged victim and remove the alleged perpetrator. V1 stated that the facility must address and report abuse to the local state agency to assure the safety of the residents. V1 stated that V1 was still conducting V1's investigation regarding R6 and R7 on 07/13/25. R7 progress note dated 07/13/25 authored by V6 (Licensed Practical Nurse, LPN) documents in part: "R7 placed on 1:1 (one-to-one) monitoring." The facility's document dated 03/26/25 through 07/16/25 and titled "Incident by Incident Type" show that R6 sustained a fall on 07/13/25 at the facility. R6's progress notes dated 07/13/25 at 7:59 am authored by V23 (Licensed Practical Nurse, LPN) documents in part: "Writer standing at nurses station providing care to another resident and upon turning around writer heard another resident stating don't come near me and when writer turned around resident had her arm extended and resident walked into her arm and stumbled back losing balance falling on her buttocks." R6's care plan dated 06/30/25 documents in part R6 demonstrates movement behavior that may be interpreted as wandering, pacing, or roaming. R6 has problems understanding the immediate environment. Symptoms are manifested by: Attempting to leave the facility with a responsible escort (elopement). Pacing roaming or wandering in and out of peers' room. Goal: The resident will respond to staff redirection to re-direct attention from a potentially problematic situation (such as elopement or entering a peers' s room) when any difficult behavior occurs. Interventions: Staff will encourage R6 to sit and take breaks." ADL's (Activities of Daily Living): R6 has a "Self-Care Deficit" and R6 require assistance with ADLs to maintain the highest possible level of functioning … Interventions: Ambulation: I usually require supervision and set-up support for Walking (Verbal Cures and set-up assistance): Locomotion on Unit I usually require supervision and set-up support for	S9999		

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S9999	Continued from page 7 Locomotion on Unit: Provide frequent rest periods as indicated … Falls: R6 is at risk for falls as evidence by the following risk factors and potential contributing diagnosis: Dementia, Alzheimer's Disease: Interventions: 05/27 increase supervision, provide structured supervision discussed with therapy continued skilled Therapy: Provide me with activities that minimize the potential for falls while providing diversion and distractions." The facility's document dated 01/2019 and titled "Abuse Prevention Program" documents, in part: "Policy it is the policy of the facility to prohibit and prevent resident abuse, neglect, exploitation, mistreatment, and misappropriation of resident property and crime against a resident in the facility. The following procedure shall be implemented when an employee or agent becomes aware of abuse or neglect of a resident, or of an allegation of suspected abuse or neglect of a resident by a third party … If you suspect abuse: separate the alleged perpetrator and assure all residents safety … for the purposes of this policy, and to assist staff members in recognizing abuse, the following definitions shall pertain: 1. Abuse: the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental psychosocial well-being. Willful, as used in this definition of abuse, means the individual must have acted deliberately not that the individual must have intended to inflict injury or harm … 4. Physical Abuse: hitting, slapping, pinching, kicking, etcetera it also includes controlling behavior through corporal punishment. The facility's undated policy titled "Incident/Accidents/Falls" documents, in part: "Policy: It is the policy of the facility to ensure that any incident/accident to include falls is reported immediately to the nurse or appropriate person designated to be in charge. After the resident has had immediate attention and their safety is established, a written report will be entered into Risk Management … The facility will ensure that incidents and accidents that occur involving residents are identified, reported, investigated, and resolved. The facility will create a data base related to incidents/accidents as part of the QAPI (Quality Assurance Performance Improvement) process to enable trending and tracking. This information will be used to implement corrective actions to include any needed training to prevent reoccurrences when possible."	S9999		

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