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 08/21/2025

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: 2587837/IL2593361	S0000		08/27/2025
S9999	Final Observations Statement Of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 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 setting based on the resident's care needs. The assessment shall be developed with the active	S9999		08/27/2025

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

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S9999	Continued from page 1 participation of the resident and the resident's guardian or representative, as applicable 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. Based on interview and record review, the facility failed to administer a resident's (R1) scheduled medication for neuropathic pain and failed to document physician notification of a resident (R1) missing scheduled doses of the neuropathic pain medication when reviewed for quality of care/treatment in the sample of 3 residents (R1, R2 and R3). This failure resulted in R1 experiencing increased neuropathic pain to bilateral lower extremities for 3 days and causing R1 to not consistently sleep for 2 nights due to increased nerve pain. These regulations were not met as evidenced by: Findings Include: On 8/20/2025 at 1:26 pm, V4 (LPN) stated that if a medication has not been received from the pharmacy, the nurse should call V2 (Director of Nursing), and the V2 will request that the nurse tell the pharmacy the medication is needed stat. On 8/20/2025 at 3:17 pm, V7 (Assistant Director of Nursing) stated that because staff is at the facility to assist the residents, the nurses know when a resident's multidose blister card gets low, and the nurse should be calling the doctor for a refill. V7 stated that nurses should follow up with the pharmacy first; if a new script is needed, the nurse should inform the doctor. V7 stated that if the doctor is not reachable, the nurse should call the nurse practitioner. V7 stated that if the nurse practitioner is not reachable, the nurse must contact the medical director. V7 stated that if the doctor has not contacted the nurse back the end of the nurse's shift, the next shift nurse should follow up by reaching out to the doctor again for the medication order. R1's Care Plan (initiated on 11/7/2023, revised on 8/5/2025) documents, in part, a focus of R1 is at increased risk for alteration in pain/discomfort related to paraplegia due to history of a gun shoot	S9999		

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S9999	Continued from page 2 wound and interventions of "administer analgesic medication as ordered per plan of care" and "assess physical as well as, psychosomatic reasons for the pain. Recognize that psychosomatic pain may cause physical distress." R1's Care Plan (initiated 11/7/2023, revised 6/25/2025) documents, in part, a focus of R1 demonstrating physical and emotional impairment secondary to neurological damage caused by neuropathy and spinal cord injury. Facility's policy titled Medication Administration undated documents, in part, “Purpose: To ensure that resident medications are administered in a timely manner and documentation is completed to substantiate administration. Policy: Unless otherwise specified by the physician, medications will be administered within 60 minutes before or after the facility's dosing schedule, except before or after meal orders and non-routine time ordered medications.” Facility's policy titled “Ordering Medications” dated May 2024 documents, in part, that Refill requests can be faxed the pharmacy's main fax number, sent via EHR (Electronic Health Record) system, reordered via (electronic link format), and/or left on the pharmacy refill voicemail. Refill requests should be sent in 72 hours prior to the last dose. Facility's policy titled “Guidelines For Pain Management” undated documents, “Purpose: It is the intent of the facility to promote resident independency, comfort, and to preserve resident dignity in an ongoing effort to promote the highest level of quality for their lives. One aspect of this commitment is to maintain an effective pain management plant to provide residents the means to receive necessary comfort, exercise greater independence, and therefore enhance their overall welfare and well-being.” This policy also documents, in part, that with chronic pain, many residents may have conditions which cause them to experience chronic pain; principles of treating chronic pain include pain medication is usually more successful for attaining pain relief if given routinely, not PRN. The resident’s plan of care must be specific for each resident related to their pain and the management plan in place for pain relief and comfort which include interventions of any ordered medications. Lastly, this policy documents, “PAIN is ‘whatever the experiencing person says it is, existing whenever the experiencing person says it does". Facility's Job Descriptions for Registered Nurse (RN)	S9999		

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S9999	Continued from page 3 and Licensed Practical Nurse (LPN) (both undated) document, in part, that for the nursing responsibility for drug administration, RN's and LPN's ensure that an adequate supply of floor stock medications, supplies, and equipment is on hand to meet the nursing needs of the resident and reports needs to the Nurse Supervisor, and orders prescribed medications, supplies and equipment as necessary, and in accordance with established policies. Findings Include: R1's Admission Record documents, in part, diagnoses of paraplegia, polyneuropathy, chronic pain syndrome, hyperlipidemia, neuromuscular dysfunction of bladder, insomnia, acquired absence of kidney, puncture wound of abdomen, assault by other firearm discharge, need for assistance with personal care, resistance to multiple antibiotics, dependence on wheelchair, and constipation. R1's Minimum Data Set (MDS), dated 6/20/2025, documents, in part, a Brief Interview for Mental Status (BIMS) score of 15 which indicates that R1 is cognitively intact. On 8/20/2025 at 1:34 PM, R1 observed propelling self with R1's arms while in R1's manual wheelchair. R1 stated that R1 has paraplegia and neuropathy with R1 experiencing "pain up and down my (R1's) legs but it's primarily in my left knee, right thigh and right foot." R1 stated, "The pain is burning, tightness and sharp. It's like a shooting pain. It's real bad when it's in my foot and shoots up my leg. It's a lot of pain." R1 stated that R1 uses a massager to help with this neuropathic pain since it's on and off all day; however, the massager doesn't make the pain go away, just "slows down the hurting." R1 stated that R1 has scheduled medication for the neuropathy pain which is Pregabalin 200 milligrams (mg) three times a day. R1 stated that R1 does have an order for Hydrocodone/Acetaminophen, but "Hydrocodone doesn't help with my neuropathy pain if I am not getting my scheduled Pregabalin." R1 stated that R1 received 2 doses of Hydrocodone/Acetaminophen over this past weekend (8/15/2025 to 8/17/2025) when the facility did not administer R1's Pregabalin, but "it (Hydrocodone/Acetaminophen) didn't work." R1 stated, "I couldn't sleep all Saturday (8/16/2025) and Sunday (8/17/2025) nights. I stayed up all night with shooting pain. I couldn't go to sleep. I finally felt relief when I got it (Pregabalin) on Monday (8/18)." R1 stated that on Wednesday, 8/13/2025, around 7:00 AM, R1 near V4 (Licensed Practical Nurse, LPN) and V9 (LPN) hearing	S9999		

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S9999	Continued from page 4 V9 saying to V4 that they “put in another order because I only have 2 days left of my medication, the Pregabalin.” R1 stated that the Pregabalin must not have been reordered because R1 took the last dose of Pregabalin on 8/15/2025 at 1:00 PM. R1 stated that V14 (LPN) administered R1’s Baclofen on 8/15/2025 at 9:00 PM, but not dose of Pregabalin 200 mg. R1 stated that on the night of 8/15/2025, R1 had “severe nerve pain” and asked for a Hydrocodone 5/325 mg PRN (whenever needed) dose. R1 stated that R1 did not received any of the three doses of Pregabalin 200 mg on Saturday (8/16/2025) and Sunday (8/17/2025). R1 stated, “I couldn’t take it. Every time I tried to move, the pain really hurt, and it continued. It didn’t slow down.” R1 stated that on 8/18/25, R1 did not receive the 9:00 AM or 1:00 PM doses of the Pregabalin 200 mg, and R1 finally received the Pregabalin 200 mg on Monday evening dose on 8/18/2025 (scheduled at 9:00 PM). R1’s Medication Administration Record (MAR), dated August 2025, documents, in part, a medication order of Pregabalin 100 mg capsules, Give 200 mg by mouth three times a day for Neuropathy, with scheduled times of 9:00 AM, 1:00 PM, and 9:00 PM. The following documentation for R1’s Pregabalin 200 mg is noted: 8/16/2025 for 9:00 AM, 1:00 PM AND 9:00 PM: V8 (LPN, Former Employee) documents a pharmacy code of “9” which indicates “Other / See Nurse Notes.” 8/17/2025 for 9:00 AM and 1:00 PM: V4 (LPN) documents a pharmacy code of “9” which indicates “Other / See Nurse Notes.” 8/17/2025 for 9:00 PM: V5 (Registered Nurse, RN) documents a pharmacy code of “9” which indicates “Other / See Nurse Notes.” 8/18/2025 for 9:00 AM and 1:00 PM: V4 (LPN) documents a pharmacy code of “9” which indicates “Other / See Nurse Notes.” R1’s eMAR Progress Notes document, in part, the following correlating documentation for R1’s Pregabalin 200 mg from the August 2025 eMAR: 8/16/2025: No eMAR Medication Administration Nurses Notes from V8 (LPN, Former Employee) for Pregabalin 200 mg scheduled 9:00 AM, 1:00 PM AND 9:00 PM. 8/17/2025 at 9:24 AM: V4 (LPN) documents an eMAR Medication Administration Nurses Note for Pregabalin of “Awaiting pharmacy delivery.” There is no eMAR Medication Administration Nurses Note from V4 for the	S9999		

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S9999	Continued from page 5 Pregabalin 200 mg scheduled at 1:00 PM. 8/17/2025 at 10:37 PM: V5 (RN) documents an eMAR Medication Administration Nurses Note for Pregabalin of "Awaiting pharmacy delivery." 8/18/2025 at 9:19 AM and 2:42 PM, V4 (LPN) documents eMAR Medication Administration Nurses Notes for Pregabalin of "Awaiting pharmacy delivery" for the Pregabalin 200 mg scheduled doses of 9:00 AM and 1:00 PM. R1's eMAR, dated August 2025, documents, in part, a medication order of Hydrocodone-Acetaminophen 5-325 mg, Give 1 tablet by mouth every 8 hours as needed (PRN) for pain. The documentation for R1's Hydrocodone-Acetaminophen 5-325 mg PRN is documented, in part, as follows: 8/15/2025 at 11:01 PM: V14 (LPN) documents administration with R1's pain scale as 3 on a 0 to 10. 8/17/2025 at 8:00 AM: V4 (LPN) documents administration with R1's pain scale as 5 on a 0 to 10. On 8/20/2025 at 2:33 PM, V4 (LPN) stated that on 8/13/2025, V9 (LPN) informed V4 to follow up with trying to get a new prescription for R1's Pregabalin 200 mg due to the low amount of capsules remaining for R1. V4 stated that when the pharmacy multidose blister pack (which stores each Pregabalin capsule in numbered blister pouches on a card) is around 8 to 10 capsules remaining, V4 will start the process of obtaining replacement medications, so the resident does not run out of Pregabalin. V4 stated that V4 called the doctor's office for V11 (Attending Physician) and left a message for the need for R1's new Pregabalin prescription with unknown office staff. V4 stated that on Friday, 8/15/2025, R1's Pregabalin supply (amount of capsules remaining in the controlled substance box) was due to be used completely on 8/15/2025, and when V4 called the pharmacy, V4 was informed that there was no prescription for Pregabalin 200 mg to send the new supply. V4 stated that on 8/17/2025, when V4 started V4's day shift, R1 was complaining of pain, and V4 medicated R1 with Hydrocodone-Acetaminophen 5-325 mg PRN. V4 stated that on 8/17/2025, R1's Pregabalin 200 mg capsules were not present in the facility, and R1 did not receive the scheduled 9:00 AM and 1:00 PM doses on V4's shift. V4 stated that on 8/17/2025, V4 stated that V4 phoned V10 and the physical medicine doctor about R1 not having the Pregabalin in the facility. When asked if V4 documented these physician	S9999		

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S9999	Continued from page 6 notifications, V4 stated that V4 only made an eMAR note. V4 stated that on 8/18/2025, R1 still did not have the Pregabalin in the facility to administer to R1 at 9:00 AM and 1:00 PM. V4 stated that V4 phoned the pharmacy at the end of V4's shift on 8/18/2025, and V4 was informed that the Pregabalin for R1 was being delivered on 8/18/2025. On 8/21/2025 at 2:02 PM, V14 (LPN) stated that V14 was the evening shift (3-11PM) for R1 on 8/15/2025. V14 stated that V14 had received in nursing report from V4 (LPN) that they were expecting the Pregabalin from pharmacy. V14 stated that V14 either called R1's primary doctor (V11) or the on-call doctor's service to obtain more Pregabalin for R1 but couldn't remember exactly which one, and V14 did not receive a return doctor's phone call. V14 stated that V14 did not document the doctor phone call on 8/15/2025. V14 stated that for R1's Pregabalin 200 mg scheduled dose on 8/15/2025 at 9:00 PM, R1 had the "last dose given" which was 1 capsule. When informed that R1's Pregabalin order was for Pregabalin 100 mg and to give 2 capsules for the 200 mg dose, V14 stated that V14 is "pretty sure" that the one Pregabalin capsule was a 200 mg dose. V14 stated that R1 complained of pain to R1's legs around 11:00 PM on 8/15/2025, and V14 medicated R1 with a Hydrocodone-Acetaminophen 5-325 mg PRN dose. On 8/20/2025 at 6:11 PM, V8 (LPN, Former Employee) stated that V8's last day of employment at the facility was 8/16/2025. V8 stated that R1 is alert, oriented, needs ADL help due to paraplegia and has pain in R1's legs which radiates down R1's legs. V8 stated that on 8/16/2025, V8 was R1's nurse for the day and evening shifts (7 AM to 11 PM). V8 stated that R1's Pregabalin 200 mg capsules were not in the controlled substance box in the medication cart. V8 stated that on 8/16/2025, V8 called the pharmacy, and they said that they needed a prescription for the Pregabalin. When asked if V8 notified R1's doctor about R1 not receiving R1's scheduled 9 AM/1PM/9PM doses on 8/16/2025, V8 stated that V8 could not remember if V8 called a doctor; if V8 spoke over the phone or via text for a doctor; or if V8 left a voicemail message for a doctor about R1's missing Pregabalin doses. When asked if V8 documents when V8 notifies a doctor of a resident missing a scheduled pain medication, V8 said that V8 would put a note in the electronic health record (EHR) generated from the eMAR. (Review of R1's eMAR Medication Administration Nurses Notes for Pregabalin documentation on 8/16/2025 shows no eMAR Medication Administration Nurses Notes on 8/16/2025). On 8/20/2025 at 2:44 PM, V5 (RN) stated that on	S9999		

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S9999	Continued from page 7 8/17/2025, V5 worked the evening shift (3-11PM) and was R1's nurse. V5 stated that V5 did not administer R1's scheduled 9:00 PM dose of Pregabalin 200 mg due to the medication not available in the facility to administer. V5 stated that on 8/17/2025, V4 had reported in nursing report to V5 that V4 had already called the pharmacy and doctor about R1's Pregabalin. V5 stated that V5 did not make a call to R1's doctors about R1 missing R1's scheduled 9:00 PM dose of Pregabalin. On 8/20/2025 at 3:17 PM, V7 (Assistant Director of Nursing, ADON) stated that when V7 returned back to work on Monday, 8/18/25, V7 was informed by the Resident Council President that R1 wanted to speak to V7. V7 stated that V7 immediately went to see R1 who informed V7 that R1 did not have or receive Pregabalin over the weekend (8/16//2025 to 8/17/2025) and no doses of Pregabalin as of their conversation on 8/18/2025. V7 stated that Pregabalin is used specifically for neurological pain and is a controlled substance (requiring a prescription). V7 stated that Hydrocodone/Acetaminophen is a narcotic medication for generalized pain and also requires a prescription. V8 stated that from the "clinical standpoint, (Pregabalin) is more effective for neurological pain." V7 stated that it's the nurse's job description and is the expectation that if a medication is not available in the facility to be administered, the nurse must call the doctor to notify the doctor. V7 stated that controlled substances that need a prescription, the nurse is expected to not wait until the medication runs out to call the doctor or call the pharmacy. V7 stated that it's the nurse's responsibility to continue to call the doctor or nurse practitioner if the nurse does not receive a timely response from the initial call placed. V8 stated, "It's not acceptable to leave a message with doctor on an answering service and not follow up." V7 stated that there has to be "effective communication" for "continuity of care." V7 stated that there used to be an on-site nurse practitioner (V12) in the facility every Monday through Friday from 9:00 AM to 4:00 PM who would write the prescription refills for a resident's controlled substance medication that was due to be empty (zero remaining) over the weekend; therefore, there would be no lapse in medication coverage. V7 stated that V12 stopped working in the facility within the past 1 to 2 weeks while V7 was off of work. V7 stated that the if the nurse does not receive a return call back from a doctor or nurse practitioner, the nurse should call the medical director of the facility, V13. V7 stated that with R1 not receiving the scheduled Pregabalin three times a day for 2 and ½ days, R1 would be in "excruciating pain, discomfort and stress" and this would affect R1's	S9999		

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S9999	Continued from page 8 mood, where R1 would “not be a happy client.” On 8/20/25 at 4:19 PM, V2 (DON) stated that Pregabalin is a controlled substance that requires a prescription from the doctor for pharmacy to refill this medication. V2 stated that nurses are expected to notify a resident's physician or nurse practitioner for renewal of Pregabalin prior to the medication being completely administered (zero capsules remaining). V2 stated that V12 (Former Nurse Practitioner) stopped working in the facility 2 weeks ago, and nurses are expected to follow up with the primary doctors/nurse practitioners for medication refills. V2 stated that V15 (Nurse Practitioner) is now managing some residents, including R1, for pain management needs. When asked about V2 being notified or was V2 aware of R1's Pregabalin not being administered as scheduled, V2 stated that V2 worked 4 hours in the facility on 8/15/2025 and was not answering or taking work phone calls over the weekend (8/16-8/17/2025) adding, "I (V2) was MIA (missing in action)." V2 stated that when a nurse goes to administer a medication to a resident and the medication is not available in the facility, the nurse will document a pharmacy code of 9 and will document the reason why the medication was not administered. V2 stated that the nurse is to notify the doctor also of the resident missing a scheduled medication as ordered by the doctor. V2 stated, "They (nurses) should be documenting the doctor when they notify them (doctors)." On 8/21/2025 at 12:50 PM, V15 (Nurse Practitioner) stated that V15 is the physical medicine nurse practitioner seeing several residents, including R1, in the facility for pain management and evaluates frequency needs for narcotic medications. V15 stated that V15 visited R1 on 8/18/25 and that R1 has paraplegia. V15 stated that R1 has used Hydrocodone-Acetaminophen sparingly (1 to 2 times) and that nurses verified this as well. V15 stated that R1 is on scheduled medications for R1's pain, such as Pregabalin, and Pregabalin has an indicated use for neuropathic or polyneuropathy pain. V15 stated that narcotics, like Hydrocodone-Acetaminophen, that are not needed long-term, should be weaned off, especially if the resident's pain is controlled by other medications. When asked the potential of R1 not receiving scheduled Pregabalin as ordered, what are potential risks that R1 can experience, and V15 stated that R1’s pain would increase and not be controlled. When asked how many days can a resident be without pain, or experiencing pain, when the resident is not receiving their scheduled doses of Pregabalin, V15 stated that V15 cannot give an exact time frame, but Pregabalin is a	S9999		

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S9999	Continued from page 9 medication that needs to “build up in the system, and we don’t want a lapse in giving this medication in my professional opinion. (B)	S9999		