| 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 12/09/2025 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **AMBASSADOR NURSING & REHAB CENTER** | **4900 NORTH BERNARD , CHICAGO, Illinois, 60625** |

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| S0000 | Initial Comments<br><br>Facility Reported Incident of 10/24/2025/265949 | S0000 | | 12/22/2025 |
| S9999 | Final Observations<br><br>Statement of Licensure Violation:<br><br>300.610a)<br><br>300.1210a)<br><br>300.1210b)<br><br>300.1210d)6)<br><br>Section 300.610 Resident Care Policies<br><br>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<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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 | | 12/22/2025 |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| S9999 | Continued from page 1<br>participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)<br><br>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. Restorative measures shall include, at a minimum, the following procedures:<br><br>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:<br><br>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.<br><br>These regulations were not met as evidenced by:<br><br>Based on observation, interview and record review, the facility failed to develop and implement interventions to prevent a resident from sustaining a serious fall related injury for one of three residents (R7) in the sample of thirteen. This failure resulted in R7 sustaining a subarachnoid bleed (brain bleed) after falling.Findings include:<br><br>Final Incident Report (11.6.2025) documents, in part:<br>At approximately 5:00 AM, resident was noted sitting on the floor in the hallway. Resident noted with an open area to the back of his head.<br><br>Resident was immediately assessed by NOD (Nurse on Duty). First aid was provided. Resident sent to emergency room for evaluation. Resident admitted with Subarachnoid hemorrhage and two staples to the back of head. Physician and family notified. Investigation initiated.<br><br>The facility completed its investigation through medical review and interviews. Based on facility review the resident fell backwards suddenly and sustained injury to the back of head. The resident remains in the hospital with a diagnosis of Subarachnoid hemorrhage and two staples to the back of head. Resident BIMS | S9999 | | |

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| S9999 | Continued from page 2<br>(Brief Interview of Mental Status) is 10. Prior to ambulating resident removed helmet and was non-compliant with safety interventions.<br><br>R7's medical record (Face Sheet) documents R7 is a 45-year-old with diagnoses including but not limited to: Disease of spinal cord, Ataxia, Schizophrenia, Epilepsy. Extrapyramidal and movement disorder, Abnormalities of gait and mobility and restlessness and agitation. R7's MDS documents R7's BIMS (Brief Interview for Mental Status) score of "10" or moderately cognitively impaired.<br><br>On 12.5.2025, at 11:21 AM via telephone, V12 (RN-Registered Nurse) said, I was on the floor when R7 fell. I didn't witness the fall; I saw him on the floor. He was getting agitated; he didn't want to be touched. He was in bed when I last checked on him. To be safe, his helmet should be on all the time. What would be safe for him would be to do 1:1 (supervision). He was 1:1 and had a sitter for a long time when he was first admitted. He gets out of bed constantly. He's currently not 1:1 and doesn't have a sitter. He did not have a sitter at the time of the fall. He was in a different room when he fell; that's maybe ten rooms from the nurse's station. That's too far. When he came back from the hospital, he was put in a room by the nurse's station. You can see into the room from the nurse's station, but you might not be able to get to him in time if he stands up.<br><br>On 12.5.2025 at 2:00 PM, V2 (Director of Nursing) said, R7 was admitted with TBI (Traumatic Brain Injury). He was more bedridden when first admitted. I think he's walking with a walker. They called me around 5:00 AM. Staff told me he was walking in the hallway and fell. He didn't have his helmet on. My intervention was to move him closer to the nurse's station so that we could monitor him. Its better. The nurses can watch him from the nurse's station while doing their charting. We reeducate him when he's non-compliant with interventions. He's not alert so he doesn't really comprehend, it's probably not effective. He came with helmet from the hospital, I don' know that anyone has tried a new helmet.<br><br>On 12.5.2025, at 3:28 PM, V15 (Restorative Nurse) either me or V20 (MDS Coordinator) would do fall care plans. I can't recall if I did the fall care plan for R7, but I know that he has one. I don't know when he came, but he hasn't been here so long. I don't know when exactly the sitter discontinued, but I think it was less than two months. I don't know why the sitter was discontinued. CNAs were assigned as sitters for the | S9999 | | |

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| S9999 | Continued from page 3<br>resident. I can't recall if he had any falls while he had a sitter. The helmet we implemented because he had a fall, but he's non-compliant. The staff monitor him (CNAs, nurses). We do rounds, try to keep him up in the dining room. I'm going to say we round on him like every hour. We encourage to keep the helmet on, he has a low BIMS score. Sometimes he understands, sometimes he doesn't.<br><br>V20 was not available for interview.<br><br>On 12.5.2025, at 4:20 PM, V18 (CNA-Certified Nursing Assistant) said R7's current room is across from the nurse's station. V18 said, R7's previous room was at the end of the hallway. You couldn't see it from the nurse's station unless you got up and looked down the hallway.<br><br>On 12.5.2025, at 4:28 PM, R7 awake, alert, sitting in wheelchair in dining room. R7's wearing his helmet, strap not secured, helmet on backwards. V16 (CNA-Certified Nursing Assistant) sitting next to resident. V16 said, I tried to put his helmet on, but he won't let me. R7 said, my helmet is okay.<br><br>On 12.5.2025, at 4:34 PM, V17 (RN-Registered Nurse), took R7's helmet off, turned it around, then placed back on resident's head.<br><br>On 11.3.2025 at 4:12 AM, R7's Nurses Note documents, in part: Resident noted on the floor by hallway. He has a behavior of repeatedly getting out of bed despite education. He has bleeding minimal back of head but refused assessment refuse further assessment. Patient agitated. 911 was called. 911 transferred to (local hospital).<br><br>On 11.3.2025 R7's hospital record documents, in part: The patient was brought in by the ambulance for a fall this morning. He admits to photophobia, frontal headache. CT Head without contrast, Impression: 1. Bilateral anterior frontal lobe subarachnoid hemorrhage. 2. Small right convexity and left parafalcine subdural hematomas measuring up to 4mm.<br><br>On 11.3.2025-12.5.2025 R7's Progress notes do not document when 1:1 sitter was discontinued or why.<br><br>R7's falls care plan initiated 7.17.2025, revised 7.25.2025 does not list close monitoring as an intervention.<br><br>(A) | S9999 | | |