

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145343	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/09/2025
NAME OF PROVIDER OR SUPPLIER  Ambassador Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  4900 North Bernard Chicago, IL 60625	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39779</p> <p>Based on interview, and record review the facility failed to prevent resident to resident physical abuse for 1 (R2) of 4 (R1, R3, R4) residents reviewed for abuse. This failure resulted in R2 sustaining swelling to the left side of R2's face near the eyebrow.</p> <p>Findings Include</p> <p>R2 has diagnosis not limited to Long Term (Current) use of Anticoagulants, Insomnia, Fall, Adult Failure To Thrive, Low Back Pain, Cerebrovascular Disease, Aphasia Following Cerebral Infarction, Nontraumatic Subarachnoid Hemorrhage from Unspecified Intracranial Artery, Acute Embolism and Thrombosis of Unspecified Deep Veins of Unspecified Lower Extremity, Acute Kidney Failure, Seizures, Respiratory Failure, Unspecified with Hypoxia, Emphysema, Dysphagia, Hypertensive Heart Disease, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side. R2's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 12 indicating moderate cognitive impairment.</p> <p>R2's Progress note dated 04/22/25 13:19 document in part: Incident Note Text: Another patient (R3) made contact with resident (R2). Immediately separated, Code Gray called. Swelling on Left eyebrow.</p> <p>R2's Progress note dated 04/22/25 13:41 document in part: Summary for Providers Situation: The Change in Condition/s reported on this Evaluation are/were: Other change in condition Outcomes of Physical Assessment: Positive findings reported on the resident/patient evaluation for this change in condition were Skin Status Evaluation: Other Nursing observations, evaluation, and recommendations are: Another patient made contact with resident. Code Gray called. Swelling on Left eyebrow.</p> <p>R2's Progress note dated 04/22/25 23:30 document in part: Nursing Progress Text: 6:10 pm-Resident returned from the hospital. Slight swelling noted to left brow area. Neuro checks ongoing.</p> <p>R3 has diagnosis not limited to Long Term (Current) use of Aspirin, Long Term (Current) use of Oral Hypoglycemic Drugs, Cataract, Seizures, Extrapyrimal and Movement Disorder, Atherosclerotic Heart Disease of Native Coronary Artery, Thyrotoxicosis and Conduct Disorder. R3's MDS document 99 resident was unable to complete the interview.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R3's Petition for Involuntary/Judicial admitted d 04/22/25 document in part; R3 with a diagnosis of Conduct Disorder, Dementia and other comorbidities is allegedly displaying physically aggressive behavior. It is alleged that R3 hit a staff member and another resident in the face. Resident is a danger to himself and others and is in need of immediate inpatient medical attention.</p> <p>R3's Progress note dated 04/11/25 17:07 document in part: Behavior Charting Describe Behavior/Mood: R3 was being verbally and physically aggressive. What was the resident doing prior to or at the time of behavior/mood: on the smoking patio asking for more cigarettes and got angry when he was told he smoked all of the cigarettes he could get on this smoke break. Interventions attempted: writer attempted to make him come back inside the facility. Effectiveness of the interventions: unsuccessful R3 was steadily being verbally and physically aggressive. R3 is being sent out to hospital for evaluation.</p> <p>R3's Progress note dated 04/22/25 14:34 document in part: Summary for Providers Situation: The Change in Condition/s reported on this Evaluation are/were: Behavioral symptoms (e.g. agitation, psychosis) - Behavioral Status Evaluation: Physical aggression Verbal aggression. Nursing observations, evaluation, and recommendations are Writer passing by the doorway noted pt (patient) (R3) standing by roommate (R2) bed and made contact with another patient (R2). Immediately separated. Code Gray called. Pt educated and tried to redirect not effective continue to be verbally/physically aggressive.</p> <p>R3's Progress note dated 04/23/25 08:15 document in part: Resident was involuntarily petitioned for aggressive behavior.</p> <p>R3's Progress note dated 04/23/25 09:42 document in part: General Progress Note Text: Psychiatric Progress Note. Neurocognitive Disorder- Present Judgment: Poor Insight: Poor Recommendation/Treatment Plan: GDR (Gradual Dose reduction) not indicated due to persisting symptoms.</p> <p>R3's Progress note dated 04/24/25 13:00 document in part: Nurses Note: R3 was admitted on behavioral floor. DX (diagnosis): Major depressive Disorder.</p> <p>R3's Care Plan document in part: Focus: Aggressive Behavior: R3 displays behavioral symptoms related to: Poor and/or ineffective coping skills. These behaviors are manifested by verbal abuse/aggression. These behavioral symptoms are manifested by physical abuse/aggression. Date initiated 04/11/25. Goal: R3 will comply with staff redirection and behave in a safe and respectful manner.</p> <p>On 05/07/25 at 01:21 PM Surveyor attempted to interview R3. R3 did not respond to questions that were asked. V5 (Certified Nurse Assistant) 1:1 sitter was observed at R3's bedside and said R3 does not respond to questions.</p> <p>Reportable dated 04/22/25 document in part: Initial Report. Brief Description of Incident: R3 allegedly made contact with R2. R3 placed on 1:1. R2 and R3 being sent to the hospital for evaluation.</p> <p>Reportable dated 04/28/25 document in part: Final Report: The facility has concluded its investigation. R2 and R3 sent to hospital due to irritability and for evaluation. R2 reported R3 engaged with him (R2) in a disagreement and R3 made contact with him (R2). There are no residents/witnesses that witnessed R3 making contact with R2. Therefore, the facility determines the allegation unsubstantiated.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Document titled Statement dated 04/24/25 document in part: V9 (Registered Nurse) stated she was trying to break up the fight between R2 and R3 and R3 struck V9 in the shoulder and pulled V9's hair.</p> <p>On 05/07/25 at 12:52 PM R2 stated I was sitting here on the bed facing the door eating my lunch. No one was in the room but me and R3. R3 was slamming drawers, and I told him (R3) to stop. R3 was taking the other roommate belongings. I turned around and R3 started slamming things again. When I was eating R3 came behind me and hit me on the left side of my face on the eyebrow and it was swollen. I got up, R3 was acting like he (R3) was going to hit me and grabbed him then I lost my balance and fell on bed. R3 was between my legs trying to hit me in my face. I tried to kick my feet when R3 was swinging. The nurse came in here and got R3 off of me. It happened around lunch time, and they sent me to the hospital.</p> <p>On 05/07/24 at 12:35 PM R4 stated There have been several fights in the hallway. On 04/22/25 I could hear the commotion, but I did not witness the abuse. You can hear the certified nurse assistants and nurses running and calling for help, so you knew something was going on. I heard the commotion and some curse saying m****f****r.</p> <p>On 05/07/25 at 01:13 PM V4 (Licensed Practical Nurse) stated Recently R3 was transferred to the second floor because he (R3) was violent with the social worker. R3 was aggressive to his (R3's) roommate. R3 has 1:1 monitoring all shifts now. If R3's breakfast was late R3 will throw a fit and get aggressive. He was violent to the paramedics. R3 has been on 1:1 since the incident happened with R2.</p> <p>On 05/07/25 at 01:21 PM V5 (Certified nurse assistant) stated R3 is not really verbal but is impatient and physically aggressive, I witnessed R3 behaviors, R3 doesn't talk much, try to get people out the way and shove them. On 04/22/25 I came up after they petitioned R3 out and sent R3 to the hospital for a psych evaluation. R3 has had a 1:1 sitter since he (R3) returned to the facility. I heard R2 got hit in the head.</p> <p>On 05/07/25 at 01:30 PM V6 (Registered Nurse) stated R3 has had a 1:1 sitter since he (R3) came back from the hospital on 05/02/24.</p> <p>On 05/07/25 at 02:21 PM V3 (Assistant Director of Nursing) stated I was here in the building in my office when the nurse reported R3 hit R2. R3 was just returning to the facility because R3 had went to the hospital for behaviors, agitation. During the admission process R3 was put in the room with R2. The nurse reported R3 hit R2 and when I got there the staff was taking R3 to the first floor. The staff separated R2 and R3 then we initiated 1:1 for R3 immediately. V9 (Registered Nurse) did the assessment and R2 was sent to the emergency room for evaluation. R2 had swelling to the left lateral side of the head near the eye. I asked what happen, R2 said I was eating and when I said don't take my wheelchair the guy (R3) hit him (R2). The abuse policy is to notify the administrator, separate the residents, initiate 1:1, do a full head to toe assessment, send to the hospital to do a CT (Computed Tomography) and initiated risk management. The policy is for abuse prevention. V3 then read the abuse prevention program and resident rights policy aloud. To prohibit and prevent resident abuse, neglect, exploitation, mistreatment, and misappropriation of resident property and a crime against a resident in the facility. The resident rights policy is the right to be free from verbal, sexual, physical or mental abuse. From what I saw R2 had swelling so of course I would say yes R2 was abused. R3 ambulates in a wheelchair. I talked to the R2 and the nurses, but I was not able to interview R3. R3 gave me a blank stare and would not answer when I asked what had happened. This was my first time trying to talk to R3 and I never tried to talk to R3 before this incident.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/07/25 at 02:45 PM V8 (Social Service Director) stated I did not witness the incident between R2 and R3, I was taking statements. R2 said R3 got physically aggressive and hit him (R2) by the eyebrow, somewhere in the face. R3 went out for a psych evaluation and R2 went out for a well-being check. R3 can become verbally and physically aggressive especially for smoking. R3 want to smoke at times and not smoking R3 easily becomes agitated. I was not able to interview R3 because R3 will not respond to any questions. R3 will tell you no for things he does not want. R3 got sent out on 04/11/25 for aggressive behavior. When R3 was readmitted R3 has a 1:1 sitter and is separated from R2 by floors. R3 tried to punch me on 04/11/25 and I was afraid for the resident's safety. R3 was on the smoking patio and wanted more cigarettes. The residents receive 2 cigarettes per smoke break and R3 came charging toward the monitor via wheelchair. R3 was told you can't go that way you had your 2 cigarettes and R3 tried to punch me when I was holding onto his (R3's) wheelchair. On 04/22/25 V9 (Registered nurse) said she (V9) heard the commotion, she (V9) immediately intervened and separated R3 from R2. V9 said R3 struck her (V9) in the shoulder and pulled her (V9) hair.</p> <p>On 05/07/25 at 03:16 PM V2 (Director of Nursing) stated The only thing I know is V1 (Administrator) put R3 on 1:1, presuming because of the incident that happen between R2 and R3 because of prevention and safety measures. The Abuse Policy is we want to keep residents safe, prevent harm, separate, 1:1, and if the resident need to be sent out we petition them out.</p> <p>On 05/07/25 at 03:21 PM Per telephone interview V9 (Registered Nurse) stated I was going to pass medications, looked in and saw R3 charging towards R2. R3 was really mad and R3 was sent out for another behavior. R3 was trying to hit R2. R2 was in bed and R2 was screaming when I came in between them R3 shoved me. I don't know what happen before I came into the room. R2 was at the bottom of the bed facing towards the door and R2 looked like he (R2) was trying to stand. R2's face did not look right to me, the left brow looked slightly swollen to the left side. R3 was charging at me and the activity aide. The activity aide tried to stop R3 from charging me and the activity aide stopped R3 when R3 was pulling my hair. R3 grabbed the wheelchair and tried to hit me with the wheelchair so I had to put the wheelchair in front of me. We could not get R3 to calm down and we called 911. I believe R3 has behaviors and R3 had just come back from the hospital. The reason R3 was sent out was due to aggressive behaviors. The incident happened between 01:00 pm and 01:30 pm.</p> <p>On 05/07/25 at 03:38 PM Per telephone interview V10 (Registered Nurse) stated I did receive R2 when he (R2) came back from the hospital and there was some swelling on his face, it could have been his brow, but I don't remember. R2 mentioned he had an incident with another resident (R3), an altercation but did not go into detail.</p> <p>On 05/07/25 at 04:31 PM V12 (Licensed Practical Nurse) stated On 04/11/25 we wanted to give R3 medication, and the paramedics had difficulty to take R3. The paramedics said they could not force R3. I called the police and doctor to send R3 out. R3 was so aggressive the paramedics finally took R3. R3 hit the social worker. We had R3 petitioned out for a psych evaluation.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/08/25 at 12:13 PM V13 (Social Service Coordinator) stated I believe a code gray was called for the incident between R2 and R3. I came to the second floor and the best way to describe it was coax. R3 was put on 1:1 and a different floor. V9 (Registered Nurse) went to break R2 and R3 up then R3 hit her (V9). I think it was in her (V9's) face because V9 was pointing to her (V9) head. R2 was sent to the hospital and had redness near the eye. Based on what V9 was telling me R3 was displaying aggressive behavior, was placed on 1:1 and sent out to the hospital. R3 was petitioned out for about a week and within about 20 minutes after R3 returned a code grey was called. When a resident displays physical or verbal aggression for staff to come assist and are having issues of calming the resident down a code grey is called. On 04/11/25 when on the smoke patio V8 (Social Service Director) was out there. The residents receive 2 cigarettes per break and V8 told R3 he could not have any additional cigarettes. V8 went to the smoke monitor and R3 almost ran a resident over. V8 and I were trying to calm R3 down and we were trying to bring R3 inside. R3 was trying to ram his wheelchair into both of us. V8 lost her footing and fell to the ground. R3 continued a couple of times to ram the wheelchair into me. R3 eventually came inside, and I was following after him (R3) because R3 was going toward another resident. I grabbed the wheelchair because I was concerned about the resident. When I grabbed the wheelchair R3 turned around and hit me on my cheek, knocking my glasses off. I am not sure of the reason for R3's behavior. Based on R3 being involuntarily discharged on [DATE], that would be considered as abuse, resident to resident. R3 just mumbles.</p> <p>On 05/08/25 at 12:33 PM Per telephone interview the surveyor asked V1 (Administrator) the rationale for unsubstantiating the altercation between R2 and R3 on 04/22/25. V1 stated R2 presented with no injuries. R2 went to the hospital and came back with no injuries and there were no witnesses. V9 (Registered Nurse) saw R3 approaching R2's bed and V9 intervened and separated R2 and R3 immediately. V9 said she did not see R2 and R3 make any contact. We don't know if R2's swelling was from the altercation. R3 is on a 1:1 and was diagnosed with dementia. Even if R2 is alert and oriented x3, R3 could not tell me what happened because R3 has dementia. The definition of abuse they are not willfully trying to harm someone. R3 was not willfully trying hurt R2. R3 has been fine, and something happened internally that have changed R3. The policy is to keep everyone safe and have someone there to monitor. The facility policy is to prohibits abuse. I did not see R2 being completely honest, and I can't say 100% that R3 hit R2. When a resident feel abused, they want to do a police report. I did ask R2 if it raises to a level of abuse. I did not feel and there are no witnesses that can tell me that R3 did it intentionally. R3 has dementia and I really don't feel R3 did it intentionally.</p> <p>On 05/09/25 at 12:53 PM Per telephone interview V14 (Activity Aide) stated on 04/22/25 I was in the activity closet. V9 (Registered Nurse) was screaming for help. I went to help V9 separate R2 and R3. I did not witness the altercation. When I entered the room R2 was standing by his (R2) bed. R3 was standing by his (R3) bed and V9 was in between them. We called for more help and the ambulance was called. R2 had a knot above the left eyebrow that and the knot had not been there before. R2 said R3 did that to him. R3 was getting aggressive with V9, trying to put his (R3) hands on V9. I was trying to calm R2 down because R2 was very, very upset.</p> <p>Policy:</p> <p>Titled Resident Rights undated document in part: The facility will protect and promote your rights. Abuse - You have the right to be free from verbal, physical or mental abuse, corporal punishment and involuntary seclusion.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Titled Abuse Prevention Program revised 03/01/21 document in part: It is the policy of this facility to prohibit and prevent resident abuse, neglect, exploitation, mistreatment, and misappropriation of resident property and a crime against a resident in the facility. The facility will not tolerate resident abuse or mistreatment or crimes against a resident by anyone, including staff members, other residents, consultants, volunteers, and staff of other agencies, family members, legal guardians, friends, or other individuals. 4. Physical Abuse: Hitting, slapping, pinching, kicking, etc.</p>		