STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145343	A. Building B. Wing	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ambassador Nursing & Rehab Center	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)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145343	A. Building B. Wing	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ambassador Nursing & Rehab Center	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)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** F725Based on observation, interview and record review, the facility failed to ensure sufficient staff to administer medications as ordered by physician and attend to resident's needs or care in a timely manner. These failures could potentially affect all residents residing in the facility. The findings include:On 8/5/25 At 10:50AM Observed R34 up and about, ambulatory with steady gait, alert and oriented x 3, verbally responsive. Stated medication does not come on time depending on the nurse. R34 said on 8/2/25 (Saturday) there was only 1 nurse working and the nurse on her side came late around 12noon. She said she got her morning medications around 12noon, and it is supposed to be given around 9am. Stated medications were given late because of short staff. MDS (Minimum Data Set) dated 6/5/2025 showed R34's cognition was intact. R34's physician order sheet (POS) and medication audit report dated 8/6/25 documented medications not limited to Furosemide, Magnesium, Thiamine, Cyanocobalamin, Folic Acid, Aspirin, Potassium Chloride, Divalproex, Gabapentin, Amlodipine, Metoprolol scheduled on 8/2/25 with physician ordered time at 9AM were administered at 11:34AM, 11:39AM and 11:40AM. R34's care plan dated 5/30/25 showed interventions not limited to Administer medication per physician order. On 8/5/25 at 11:26AM R46 observed sitting on wheelchair, alert and oriented x 3, verbally responsive, very upset stated that he did not get his 9am medications yet. He said he has been having pain on right leg and scored pain as 8/10. R46 said he does not need PRN (as needed) pain medication if he gets his scheduled medications around 9am. Stated he has been residing in the facility for almost 5 years and at times, his medications are given late depending on the nurse working and at times short of staff. R46 said he has been waiting for his medications for couple of hours and no staff came. On 8/5/25 At 11:33AM Observed V18 (Licensed Practical Nurse / LPN) prepared medications and prepared the following medications: Cephalexin 500mg 1 capsule, Diclofenac 50mg 1 tablet, Eliquis 5mg 1 tablet, Lisinopril 10mg 1 tablet, Metoprolol 50mg 1tablet, Magnesium oxide 400mg 1 tablet, Furosemide 40mg 1 tablet, Fish oil 1 capsule, Folic acid 1 tablet. MDS dated [DATE] showed R46's cognition was intact. R46's POS and MAR (Medication Administration record dated 8/5/25 showed medications not limited to Cephalexin, Diclofenac, Eliquis, Lisinopril, Metoprolol, Magnesium oxide, Furosemide, Fish oil, Folic acid with physician ordered time at 9AM. On 8/06/2025 10:08 AM Surveyor conducted resident council meeting attended by 6 residents including R77 and R156 and stated on 8/2/25 their medications were given late due to short of staff. They waited for 2-3 hours to get their scheduled medications. R77 said if medication is given late there is shorter time gap for the next dose of medication. R156 stated he had witnessed that his roommates have been calling for help to be changed and needed to wait for more than an hour.R77's physician order sheet (POS) and medication audit report dated 8/6/25 documented medications not limited to Furosemide, Spironolactone, Zinc oxide, Fluticasone, Jardiance, Methocarbamol, Spiriva inhaler, Allopurinol, Metformin, Gabapentin, Amlodipine scheduled on 8/2/25 with physician ordered time at 9AM were administered at 12:37PM. R77's care plan dated 5/29/25 showed intervention not limited to Administer medication as ordered. MDS dated [DATE] showed R77's was cognitively intact. R156's physician order sheet (POS) and medication audit report dated 8/6/25 documented medications not limited to Pregabalin, Vitamin C, Multivitamin, Lidocaine, Baclofen, Docusate Sodium, Polyethylene Glycol scheduled on 8/2/25 with physician ordered time at 9AM were administered at 11:29AM and 11:30AM. R156's care plan dated 11/7/23 showed intervention not limited to Administer medication as ordered.MDS dated [DATE] showed R156's cognition was intact.On 8/7/25 at 10:55am Observed R70 resting in bed, alert and oriented x 3, verbally responsive. Stated there are times that he needed to wait for at least an hour to be changed. He said at one point he waited for 3hours to be changed, and he missed his therapy session because he was late to go down. R70 said care is not done in a timely manner because of short staffing. MDS dated [DATE] showed R70's cognition was intact. He needed Partial / moderate assistance with toileting and personal hygiene, shower / bathe self, upper and lower body dressing. MDS showed R70 was Occasionally incontinent of bowel and bladder.At 8/7/25 at 11:01AM Observed R163 resting in bed on moderate high back rest, alert and oriented x 3, verbally responsive. Stated most of the time, has been calling for help but nobody would respond to call light to attend to his needs in a timely manner. Stated he needed to wait at least an hour to an hour and half to be changed due to short of staff. MDS dated [DATE] showed R163's cognition was intact. He needed Partial / moderate assistance with oral hygiene; Dependent with toileting hygiene, shower / bathe self, lower body dressing, chair / bed transfer;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145343	A. Building B. Wing	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ambassador Nursing & Rehab Center	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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** F755Based on observation, interview and record review, the facility failed to follow their policies and procedures to ensure resident received their medications according to the physician's order for 6 (R25, R34, R46, R77, R107 and R156) residents reviewed for medication administration in a sample of 35.The findings include: R34’s admission record showed admit date on 5/29/2025 with diagnoses not limited to Other seizures, Hypertensive heart disease without heart failure, Polyneuropathy, Depression, Idiopathic peripheral, Autonomic neuropathy. MDS (Minimum Data Set) dated 6/5/2025 showed R34’s cognition was intact. R46’s admission record showed admit date on 4/3/2020 with diagnoses not limited to Unilateral primary osteoarthritis right hip, Chronic obstructive pulmonary disease, Chronic pulmonary edema, Heart failure, Paroxysmal atrial fibrillation, Unspecified atrial flutter, Hypertensive heart disease with heart failure, Type 2 diabetes mellitus, Venous insufficiency (chronic) (peripheral), Iron deficiency anemia, Hyperlipidemia. MDS dated [DATE] showed R46’s cognition was intact. R77’s admission record showed admit date on 5/26/2021 with diagnoses not limited to Chronic obstructive pulmonary disease, Acute and chronic respiratory failure with hypercapnia, Chronic obstructive pulmonary disease with (acute) exacerbation, Chronic diastolic (congestive) heart failure, Hypertensive heart disease with heart failure , Venous insufficiency (chronic) (peripheral), Type 2 diabetes mellitus, Other unilateral secondary osteoarthritis of hip, Gout. MDS dated [DATE] showed R77’s was cognitively intact. R156’s admission record showed admit date on 12/21/2023 with diagnoses not limited to Paraplegia, Hyperlipidemia, Neuromuscular dysfunction of bladder, Polyneuropathy, Acquired absence of kidney. MDS dated [DATE] showed R156’s cognition was intact. On 8/5/25 At 10:50AM Observed R34 up and about, ambulatory with steady gait, alert and oriented x 3, verbally responsive. Stated medication does not come on time depending on the nurse. R34 said on 8/2/25 (Saturday) there was only 1 nurse working and the nurse on her side came late around 12noon. She said she got her morning medications around 12noon, and it is supposed to be given around 9am. Stated medications were given late because of short staff. R34’s physician order sheet (POS) and medication audit report dated 8/6/25 documented medications not limited to Furosemide, Magnesium, Thiamine, Cyanocobalamin, Folic Acid, Aspirin, Potassium Chloride, Divalproex, Gabapentin, Amlodipine, Metoprolol scheduled on 8/2/25 with physician ordered time at 9AM were administered at 11:34AM, 11:39AM and 11:40AM. R34’s care plan dated 5/30/25 showed interventions not limited to Administer medication per physician order. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145343	A. Building B. Wing	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ambassador Nursing & Rehab Center	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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/5/25 at 11:26AM R46 observed sitting on wheelchair, alert and oriented x 3, verbally responsive, very upset stated that he did not get his 9am medications yet. He said he has been having pain on right leg and scored pain as 8/10. R46 said he does not need PRN (as needed) pain medication if he gets his scheduled medications around 9am. Stated he has been residing in the facility for almost 5 years and at times, his medications are given late depending on the nurse working. R46 said he has been waiting for his medications for couple of hours and no staff came. On 8/5/25 At 11:28AM Surveyor asked V18 (Licensed Practical Nurse / LPN) regarding R46 scheduled medications and stated she came in late around 10am today, it was V2 (DON) and V15 (LPN) covered her assignment with V11 (RN orientee) and prepared R46’s medications. She said V11 attempted to give medications to R46 but did not take it stating there were medications missing. V18 attempted to administer previously prepared medications to R46 and said could not see his blood thinner medication which is pink and oval shape and did not see the Glucosamine. On 8/5/25 At 11:33AM V18 discarded previously prepared medications and prepared the following medications: Cephalexin 500mg 1 capsule, Diclofenac 50mg 1 tablet, Eliquis 5mg 1 tablet, Lisinopril 10mg 1 tablet, Metoprolol 50mg 1tablet, Magnesium oxide 400mg 1 tablet, Furosemide 40mg 1 tablet, Fish oil 1 capsule, Folic acid 1 tablet. V18 said Glucosamine tablet was not available. She said she will order it to the pharmacy. V18 administer prepared medications and R46 said “where is my Glucosamine?” V18 responded it was not available and was ordered already. R46 took prepared medications by mouth. R46’s POS and MAR (Medication Administration record dated 8/5/25 showed medications not limited to Cephalexin, Diclofenac, Eliquis, Lisinopril, Metoprolol, Magnesium oxide, Furosemide, Fish oil, Folic acid with physician ordered time at 9AM. On 8/06/2025 10:08 AM Surveyor conducted resident council meeting attended by 6 residents including R77 and R156 and stated on 8/2/25 their medications were given late. They waited for 2-3 hours to get their scheduled medications. R77 said if medication is given late there is shorter time gap for the next dose of medication. R77’s physician order sheet (POS) and medication audit report dated 8/6/25 documented medications not limited to Furosemide, Spironolactone, Zinc oxide, Fluticasone, Jardiance, Methocarbamol, Spiriva inhaler, Allopurinol, Metformin, Gabapentin, Amlodipine scheduled on 8/2/25 with physician ordered time at 9AM were administered at 12:37PM. R77’s care plan dated 5/29/25 showed intervention not limited to Administer medication as ordered. R156’s physician order sheet (POS) and medication audit report dated 8/6/25 documented medications not limited to Pregabalin, Vitamin C, Multivitamin, Lidocaine, Baclofen, Docusate Sodium, Polyethylene Glycol scheduled on 8/2/25 with physician ordered time at 9AM were administered at 11:29AM and 11:30AM. R156’s care plan dated 11/7/23 showed intervention not limited to Administer medication as ordered. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145343	A. Building B. Wing	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ambassador Nursing & Rehab Center	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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/7/25 at 11:49AM V2 (Director of Nursing / DON) stated nurses are expected to administer Medications to residents according to physician order. Should follow 5R’s (right route, right resident, right time, right frequency, right dose) in giving medications. V2 said nurses should give meds 60minutes before and after physician ordered time. She said If the order time is at 9am, nurse is expected to give medication between 8am to 10am. If medication was given at 11:30am, it is considered late and not following physician ordered time. V2 said if blood pressure, blood sugar, pain medication was not given according to physician ordered time could potentially affect blood pressure, blood sugar or aggravate pain. Facility’s LPN’s and RN’s job description (undated) showed in part: Prepares and administers medications as ordered by the physician. Facility’s medication administration policy (undated) showed in part: To ensure that resident medications are administered in a timely manner. Unless otherwise specified by the physician, medications will be administered within 60minutes before and after the facility’s dosing schedule. Licensed professional nurses administer medications according to times documented on the medication administration record. Medication administration pass may begin sixty minutes before the scheduled times of administration but may not exceed to sixty minutes after the scheduled times of administration. Findings Include: R25’s Minimum Data Set (MDS) dated [DATE] shows he is cognitively intact. R25's Electronic Medical Record (EMR) revealed he was admitted to the facility on [DATE] and is [AGE] years of age with diagnoses that included but were not limited to: end stage renal disease, dependence on renal dialysis, other age-related cataract, unspecified atrial fibrillation, type2 diabetes mellitus with foot ulcer, dry eye syndrome, anemia, and hypertensive heart disease without heart failure. R107’s Minimum Data Set (MDS) dated [DATE] shows she is cognitively intact. R107's Electronic Medical Record (EMR) revealed he was admitted to the facility on [DATE] and is [AGE] years of age with diagnoses that included but were not limited to: anemia in chronic kidney disease, atherosclerotic heart disease of native coronary artery without angina pectoris, hypertension, chronic obstructive pulmonary disease, and epilepsy. On 8/5/25 at 10:35 AM, R25 in bed, stated that he has been in the facility for about eight months. He does not receive his scheduled medication at times and sometimes he received his medication late, and he did not receive some of his medications last Saturday 8/2/25. On 8/5/25 at 11:23 AM, R107 up in wheelchair, stated that she has been in the facility for ten years, she receives her medication late at times, and she did not receive most of her medications on Saturday 8/2/25. On 8/7/25 at 10:03 AM, V44 (Registered Nurse/RN) stated that she has been in the facility since 2016, Medication Administration Record (MAR) should be signed once the medication is given, and if MAR is not signed, then the medication is not given. She worked 3pm-11pm shift on 8/2/25 with R25 without signing the MAR. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145343	A. Building B. Wing	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ambassador Nursing & Rehab Center	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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/7/25 at 10:18 AM, V42 (Licensed Practical Nurse/LPN) stated that she has been in the facility for twenty-seven years, and she worked 7am-3pm shift on 8/2/25 with R107. Nurses should administer medication as ordered by the physician, sign the MAR, and if MAR is not signed, the medication is not given, and that will affect the resident’ well-being. On 8/7/25 at 11:12 AM, V2 (Director of Nursing/DON) stated that she has been in the facility for three months, it is her expectation that nurses will administer medication has scheduled by the physician, and sign MAR. When medications are not administered to resident as ordered it could lead to increase sickness and distress. She ensures that nurses sign the MAR once the medication is given, and no resident reported to her that medication was not administered as scheduled. Documents reviewed for this complaint are not limited to the following. R25’s Medication Administration Record (MAR) shows that fourteen medications were not signed/administered to him on 8/2/25 during the 3pm-11pm shift. R107’s MAR shows that fifteen medications were not signed/administered to her on 8/2/25 during 7pm-3pm shift. R25, and R107’s Face Sheet, POS, MAR, and Section C of MDS. Policy and Procedure titled, “Medication Administration” documents in part: Medication administration record (MAR) will be signed after for each medication administered to the resident. Resident Council Meeting Minutes from 6/24/24 to 7/29/25. Grievance/Concern Forms from 8/2/24 to 12/12/24, and 5/1/25 to 8/4/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145343	A. Building B. Wing	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ambassador Nursing & Rehab Center	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)
F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. Number of residents sampled: 35Number of residents cited: 1 Based on interviews and record reviews, the facility failed to follow provider orders and provide radiology services to one resident (R78) out of a total sample of 35 residents.Findings include: On 8/05/2025 at 11:20 AM, R78 stated experiencing coughing spells sometime last month. A provider evaluated R78 and ordered a chest x-ray. R78 stated facility never did it. R78's 7/14/2025 11:15 AM progress note by V32 (Nurse Practitioner) documents in part that R78 complained of chronic cough. As part of treatment plan, V32 ordered a chest x-ray. R78's 'Order Audit Report' documents in part that V30 (Nurse) entered the two-view chest x-ray on 7/16/2025 (two days later) at 4:47 PM on behalf of V32. On 08/06/2025 at approximately 9:30 AM, V1 (Administrator) informed surveyor that there was no chest x-ray results for R78. On 08/06/2025 at 12:22 PM, V34 (Nurse) stated the nurse practitioners or doctors will communicate to the nurses if there are new orders. The providers will put the orders in the computer unless it's a verbal or telephone order. The nurses will then have to acknowledge and confirm the order in the electronic medical record. V34 stated if the nurse doesn't see the order then they can call the provider and verify whether they still want the order. V35 (Nurse) also stated that they can follow-up with V2 (Director of Nursing) or V3 (Assistant Director of Nursing) to help verify the order. On 8/06/2025 at 3:26 PM, V30 (Nurse) stated following up with V32 (Nurse Practitioner) regarding the chest x-ray on 7/16/2025. Per V30, V32 gave a verbal order to another nurse on 7/14/2025. V30 stated the nurse should have entered it in the electronic medical record but must have forgotten to do it. V32 instructed V30 to continue with the order for chest x-ray for cough and shortness of breath so V30 entered it in the computer. V30 stated calling the contracted radiology company twice to do the chest x-ray but they never did it during V30's shift so V30 endorsed it to the oncoming shift to follow-up. R78's progress note dated 7/18/2025 at 5:30 AM documents in part that R78 continued to complain of cough and was still due for the chest x-ray. R78 called emergency services for hospital evaluation. Facility's 'Guidelines for Diagnostic Services' documents in part: It is the policy of this facility to ensure that laboratory, radiology, and other diagnostic services meet the needs of residents, that results are reported promptly to the ordering provider to address potential concerns and for disease prevention, provide for resident assessment, diagnosis, and treatment, and that the facility has established policies and procedures, and is responsible for the quality and timeliness of services whether services are provided by the facility or an outside resource. The facility will provide or obtain radiology and other diagnostic services to meet the needs of its residents.