

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 09/11/2025
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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to report an allegation of resident abuse within two hours of notification. This failure affected one resident (R1) reviewed for Reporting of Alleged Violation. Findings include: R1 is [AGE] year old with diagnosis including but not limited to: spinal stenosis, morbid obesity, other abnormalities of gait and mobility, low back pain and heart failure. R2 is [AGE] year old with diagnosis including but not limited to: depression, insomnia, aphasia, hypertensive heart disease without heart failure and facial weakness. On 9/10/25 at 10:30 am, V2 (DON) stated the following, We transferred R1 to a sister facility because he alleged that R2 hurt his arm. The incident was unwitnessed and occurred on 7/29/25. V25 (MDS Nurse) was the MOD (Manager on Duty) on that day and completed an incident report of the incident between R1 and R2. R1 had an in-house X-ray done because he complained of pain to his arm, but there were no injuries noted via X-ray and no redness. All abuse allegations are handled by V1, however in his absence I am able to send an abuse incident to IDPH. All alleged abuse incidents must be reported within 2 hours of the incident. On 9/10/25 at 10:45 am, V25 (MDS Nurse) stated the following, R1 had stated that he was in an altercation with R2 a little after 7:00 am. I was the MOD that morning, which is why I completed an incident report. The information was given directly from R1 since the incident was unwitnessed. The Administrator was notified by me immediately via telephone. I always notify the Administrator about any allegations regarding abuse immediately. On 9/10/25 at 10:56 am, V1 (Administrator) stated the following, With abuse allegations, we are to report abuse within two hours of the incident. Abuse can be physical, verbal, mental, financial, seclusion and more. Abuse can also be resident to resident, staff to resident, family member to resident, etc. All allegations are reported to me immediately. Facility Census Report dated 9/8/25 documents a total of 172 current residents. Facility Incident Report dated 7/29/25 at 7:36 am documents, R1 alleged that another resident (R2) made contact with him while he was in bed. Facility email transmittal dated 7/29/25 documents, IDPH Incident Report involving R1 was reported at 10:22 am. Facility policy titled Abuse Prevention Program documents, this report (abuse report) should be made immediately, but no longer than two hours after the allegation is made.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 145343
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