| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145343 | A. Building<br>B. Wing | 12/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Ambassador Nursing & Rehab Center | 4900 North Bernard<br>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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that a resident remain free from abuse for one of four residents (R2) reviewed for abuse in the sample of 13.Findings include:R2's medical record (face sheet) documents R2 is a [AGE] year-old admitted to the facility with diagnoses including but not limited to: Specified disorders of brain, Cardiomegaly, Electrocution, and Seizures. R2's MDS (Minimum Data Set) documents a BIMS (Brief Interview for Mental Status) score of 15 or cognitively intact.R3's medical record (face sheet) documents R3 is a [AGE] year-old admitted to the facility with diagnoses including but not limited to: Atherosclerotic heart disease of native coronary artery without angina pectoris, Hypertensive heart and chronic kidney disease without heart failure, Chronic kidney disease, and Hyperlipidemia. R3's MDS (Minimum Data Set) was not completed.Final Incident Report (10.29.2025) documents in part, (R3) alleging (R2) made contact with (R2) and noted redness to lower lip. (R3) no longer in facility. Body assessment performed on (R2) and noted with redness to left lower lip.On 10.24.2025, R2's statement documents: Resident alleged roommate struck him in the mouth after asking him to not slam door. Resident stated he asked roommate to not slam door in a calm tone.On 12.4.2025, at 3:47 PM, V1 said, R'2s and R3's incident was not substantiated. There were no witnesses (staff or residents).R2 and R3 were not available for interview.On 10.24.2025, V19's statement documents: I didn't witness the allegation. (R2) told me (R3) made contact with him. (R2) denied any pain or discomfort, and he had a little redness to lower lip.On 10.24.2025, at 3:24 PM, R2's Nursing Progress Note documents in part, Resident 1 allegedly made contact with another resident 2 and noted with redness to left lower lip.On 10.24.2025, at 2:30 AM, R3's Nursing Progress Note documents in part, resident came out from his room walking around the floor then went back to his room. After a few minutes he came to nurse's station stating that he got into argumentation (argument) with co-roommates and does (not) want to stay in that room this time.Abuse Prevention Program (revised 3.1. 2021) documents, 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.For the purpose of this policy, and to assist staff members in recognizing abuse, the following definitions shall pertain: 1. Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or any punishment with resulting harm or pain or mental anguish or deprivation by an individual.Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.4. Physical Abuse: Hitting, slapping, pinching, kicking, etc. It also includes controlling behavior through corporal punishment. |

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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|---|---|
| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>(continued on next page) |

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|---|---|
| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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:Final Incident Report (11.6.2025) documents, in part: 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.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.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 (Brief Interview of Mental Status) is 10. Prior to ambulating resident removed helmet and was non-compliant with safety interventions. R7's medical record (Face Sheet) documents R7 is a [AGE] 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. 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.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.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 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.V20 was not available for interview.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.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.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.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).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 |