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	05/10/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. The facility failed to prevent and protect residents from resident-to-resident physical abuse. This failure affects two (R1, R2) residents out of four residents reviewed for abuse. Findings include: On 05/09/2026 at 9:55AM, V3 (Licensed Practical Nurse/LPN) states she was the nurse assigned to care for R1 yesterday and had heard there was an altercation that took place between R1 and R2. V3 states she was called down to speak to V1 (Administrator) in the office. V3 states she assessed R1 and did not see any bruises and R1 denied having any pain. V3 states she called R1's doctor and received orders to send R1 to the hospital for evaluation. V3 states the incident occurred at approximately 2:30PM and she called the ambulance at approximately 4:30PM. V3 states R1 was placed on 1:1 monitoring until the ambulance arrived. V3 states her shift was supposed to end at 3:00PM so she left after calling the ambulance. V3 states she has never seen R1 be physically aggressive with anyone in the facility. R1's progress note dated 05/08/2026 at 4:28PM written by V3 (LPN) documents, R1 alleged that another resident made contact with him. Head to toe assessment completed. No new abnormalities noted. Dr. notified. Dr. ordered R1 to be sent to hospital ER for evaluation. Order noted and carried out. R1 is responsible for self. Administrator and DON aware. On 05/09/2026 at 10:03AM, R1 states he was assaulted yesterday by R2 and R2 punched him in the face. R1 states he was located on the first floor by the elevators and R2 called him an ***hole so R1 called R2 a p***y. R1 states R2 started verbally assaulting him some more and then said, you want to go outside? R1 states R2 stood up from his wheelchair and punched him in the face so R1 defended himself by blocking R2's hits and then R1 hit R2 in the head. R1 states he hit R2 in the head because R2 punched him in the face first. R1 states he called the police and filed a police report against R2. R1 states although R2 hit him in the face, he does not have any injuries. On 05/09/2026 at 10:19AM, V5 (Social Services Coordinator states there was an incident yesterday involving R1 and R2 and both residents were claiming the other one hit the other first. V5 states the facility is not sure who made contact first. On 05/09/2026 at 10:21AM, R2 states on 05/08/2026, he was located on the first floor in front of the elevator waiting for the elevator. R2 states that's when R1 came down the hall and bumped R2 with his rollator walker. R2 states he told R1 can't you see I'm here in front of you? R2 states R1 then called him Superman and a p***y. R2 states after R1 called him a p***y R2 states that's when I knocked him out. R2 states he is not a woman and do not have women body parts so R1 should not be calling him a p***y. R2 then changes his story and states R1 swung on him first and he blocked R1 and then that's when he punched R1 in the face and knocked R1 out. R2 states R1 always comes down to the first floor and walks past his room and R1 should not be down on the first floor. R2 states R1 lied to V1 (Administrator) about what happened and R1 called the police on him and filed a police report. R2 states another resident (identified as R3) was a witness to the altercation between R1 and R2. On 05/09/2026 at 10:48AM, V6 (Registered Nurse/RN) states R1 and R2 were former roommates and had a disagreement sometime last year and R1 was moved to the second floor of the facility. V6 states R2 remained on the first floor of the facility. V6 states R2 has a history of turning other residents against R1. V6 states R2 makes false allegations against R1 and has even recruited R3 against R1. V6 states now R3 has turned against R1 and does not like him because of R2. V6 (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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	states she constantly hears R3 saying lots of negative things about R1. V6 states she has never heard R2 talk negatively about R2 or R3. V6 states R1 has an independent community pass and goes out into the community everyday and usually does not return to the facility until the evening. V6 states R1 may go to the first floor to play games or go to the vending machine. V6 states R1 is usually gone from the facility for most of the day. V6 states she has never seen R1 be aggressive with any of the other residents. R2's progress note dated 05/09/2026 at 11:30AM written by V6 documents R2 was transferred to ER for psych evaluation with petition on doctors order. R2 was picked up by 2 ambulance staff in stable condition, vitals within his baseline, no changes noted to skin and resident orientation was AOX3-4 at this time. On 05/09/2026 at 11:02AM, R3 approached surveyor and stated he was a witness to the altercation between R1 and R2 on 05/08/2026 and that R2 was innocent. R3 states he was located next to the first-floor elevator sitting down on his rollator walker and saw R1 use his rollator walker to cut R2 off at the elevators. R3 states R1 pushed his walker in front of R2's wheelchair. R3 states R2 asked R1 why would you do that? and R1 said shut up you p***y. R3 states R1 kept calling R2 a p***y. R3 states R1 has been picking on R2. R3 states V7 (RN) then came over and stood in between R1 and R2 and told R1 to go up to his room on the second floor. R3 states R1 rode the elevator up but never got off but came back down to the first floor and when the elevator opened R1 flipped R2 off with his middle finger. R3 states no one witnessed this happen because R1 was on the elevator at the time. R3 states R1 then rode the elevator down to the basement but did not get off and came back up to the first floor. R3 states when the elevator doors opened, R1 then pushed his rollator walker into R2. R3 states that's when R2 jumped up from his wheelchair and punched R1 in the face. R3 states R1 then began hitting R2 back but R2 was blocking R1's punches. R3 then changes his story and states R2 only punched R1 because R1 pushed his rollator walker into R2 and R1 tried to hit R2 first.On 05/09/2026 at 12:16PM, V7 (Registered Nurse/RN) states she was the nurse assigned to care for R2 yesterday and she was located at the first-floor nurses' station when she saw there was a crowd waiting for the elevator. V7 states she then heard R1 and R2's voices so she went around from the nurses' station and saw that R1 and R2 were already separated. V7 states that R2 told her that R1 hit R2 first and R1 also told V7 that R2 was the person who hit R1 first. V7 states she did not witness either resident hit each other. V7 states she then called V3 (LPN), who was assigned to care for R1 to inform her of the incident. V7 states she then took R2 inside of his room to assess him. V7 states upon performing a full-body assessment, she did not see any bruising on R2 and R2 did not complain of pain. V7 states she then saw V1 (Administrator), V2 (Director of Nursing/DON), and social services come out of the office, and they interviewed a lot of people. V7 states after assessing R2, R2 was placed on 1:1 monitoring. V7 states she called R2's doctor to inform him of the incident. V7 states the doctor gave her orders to send R2 to the hospital for evaluation. R2's progress note dated 05/08/2026 at 2:30PM written by V7 (RN) documents R2 alleged that another resident made contact with him. Full body assessment completed and no new abnormalities found. There are no injuries MD and family notified. Administrator and DON aware. On 05/09/2026 at 1:37PM, V1 (Administrator) states he does not have video footage of the incident that occurred between R1 and R2 by the first-floor elevators on 05/08/2026. On 05/09/2026 at 3:25PM, V1 states R1 and R2 are former roommates and R2 has a history of making unfounded allegations regarding R1. V1 states there was a time when R2 told him that R1 had just passed by R2's room. V1 states he then reviewed the camera footage with R2 and did not see R1 on the camera. V1 states R2 insisted and was pointing at the camera saying he's right there. V1 states he informed R2 that R1 was not on the camera and even called the social worker in the office to verify. V1 states R2 seems to have a negative fixation on R1. V1 states he told R2 that this was not normal and that R2 needed to be evaluated. V1 states R2 then left his office while denying that he needed to be evaluated. V1 states after the incident yesterday, the facility received an order to send R2 to the hospital to be evaluated. V1 states R2 was sent out to the hospital for psychiatric evaluation today. V1 states he has had a conversation with R1 and R2 about the rules of the facility and possibly transferring them to another (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility for safety reasons. Facility Reported Incident dated 05/08/2026 documents that the facility reported allegations of abuse for R1 to the state agency.Police report dated 05/08/2026 #JK-246935 Beat/Unit 1711 for R1 and R2 documents a report of simple battery. Facility policy dated 01/2019, titled Abuse Prevention Program documents in part, This facility will not tolerate resident abuse or mistreatment or crimes against a resident by anyone, including staff members, other residents.Abuse: the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish 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.Facility policy dated 11/28/2017 titled Policy on Resident Rights, Respect & Dignity documents in part, The resident has the right. to be free from verbal, sexual, physical and mental abuse.