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	06/12/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide adequate supervision for two (R3, R4) of three residents with history of aggressive behaviors. The facility failed to ensure that R4, who required one-to-one supervision due to prior resident-to-resident altercation, was adequately supervised, resulting in another resident-to-resident altercation.Findings Include:The facility's final incident reportable for R3 and R4 dated 5/24/26 sent to State Agency on 5/29/26 at 3:38 PM reads in part: [R4] stated they engaged in an argument with [R3], and that [R3] got frustrated and pushed [R4]. [R3] denied the allegation adamantly stating he didn't make any type of physical contact with [R4]. [R3] further stated that [R4] pushed a chair that made contact with [R3's] walker and he got upset about it but never pushed [R4]. [R4] and [R3] were very upset with each other, and they verbalized threats to staff after they were separated. [R4] and [R3] placed on one-on-one monitoring. MD [Medical Doctor] informed. MD ordered [R4] and [R3] to be sent out to hospital for psychiatric evaluation due to increased irritability. [R4] and [R3] are responsible for themselves. Residents on the floor were interviewed, and no resident witnessed the allegation. Staff on the floor were interviewed, and no staff witnessed the allegation. There are no witnesses to the allegation.R3's clinical records show an admission date of 3/12/26 with listed diagnoses not limited to alcohol abuse, cocaine abuse, and heart failure. R3's Minimum Data Set (MDS) dated [DATE] shows a BIMS (Brief Interview for Mental Status) of 15, which means R3 was cognitively intact and was able to make needs known. R3's comprehensive care plan reads in part: (Date Initiated: 04/04/2026) R3 displays behavioral symptoms related to: A difficult time adjusting to the life in the long-term facility. These behavioral symptoms are manifested by: verbal abuse/aggression. [R3] shouts and uses derogatory terms against staff. [R3] has inappropriate conversations with staff and others. [R3] I display conflictual, difficult behavior with other persons related to: A difficult time adjusting to life in the long-term care facility. Behavior symptoms are manifested by: Covert/open conflict with or repeated criticism of staff and others. Behavior symptoms are manifested by: Unprovoked expressions of anger towards staff & peer (e.g., may approach neutral party & become verbally abusive), Complaints/concerns about other residents., General intolerance & limited ability to deal with frustration. History of substance abuse., Poor or ineffective coping skills.R4's clinical records show an admission date of 5/28/25 with listed diagnoses not limited to heart failure, hyperlipidemia, and chronic kidney disease. R4's MDS dated [DATE] shows a BIMS of 15, which means R4 was cognitively intact and was able to make needs known. R4's comprehensive care plan reads in part: (Date Initiated: 4/14/26) R4 has history of aggressive, inappropriate behavior. R4 has a history of aggressive, inappropriate, attention-seeking and/or maladaptive behavior. History includes conflicts/altercations with others, disrespectful, insulting, demeaning behavior, and verbal and physical aggression.R4's progress notes dated 5/24/26 at 7:20 AM documented by V22 (Licensed Practical Nurse/LPN) reads in part: [R4] alleged that another resident made contact with him. Full body assessment performed, and no new abnormalities were found. [R4] denies pain or discomfort. [R4] increasingly irritated, making threat to physically harm other residents, unable to redirect or (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wipes, he observed R4 and R3 arguing. V13 stated that he intervened immediately and separated the two residents. V13 reported that he did not hear either R3 or R4 used profanity and could not recall the specific statements exchanged between them. V13 recalled hearing R4 said something about R3 stepping on his foot. V13 stated that he did not observe any physical altercation and only witnessed the residents shouting at one another. According to V13, V12 (CNA) arrived shortly thereafter and assumed responsibility for the situation. V13 stated that he notified the nurse and reported the incident to V14 (Registered Nurse/RN). V13 could not recall who else was present in the dining room at the time of the incident. V13 stated that R4 was on one-to-one supervision due to a history of altercations with other residents and indicated that he had previously received reports regarding such incidents.O6/10/26 at 8:49 AM, a phone interview conducted with V14 (RN). V14 stated regarding the incident involving R3 and R4 on 5/24/26, V14 recalled that it occurred around 7:00 AM that V13 informed her that an incident was occurring in the dining room. After hearing a commotion, V14 and V13 proceeded to the dining room, where several residents were present. V14 stated that she did not personally witness any physical contact between R3 and R4 and only became aware of the alleged hitting through information provided by witnesses. Upon entering the dining room, V14 observed that R3 was uncooperative and moving around the dining room. V14 perceived that R3 appeared to be anticipating another incident or attempting to provoke R4. R3 repeatedly entered and exited the dining room and was not responsive to redirection despite multiple CNAs attempting to monitor and redirect R3. V14 stated R4 was seated in the dining room eating breakfast and R3 repeatedly stopped near R4's table and appeared to be expecting a confrontation. V14 stated that R3's behavior appeared provocative toward R4. V14 stated that she further observed that R3 would look at R4 in a threatening manner and continued to move throughout the dining room despite staff efforts to redirect him. V14 described R3 as aggressive and difficult to control. V14 stated that staff were actively attempting to prevent the two residents from coming into close contact and to prevent either resident from harming the other. V14 stated that R4 also called R3 derogatory names like Pu**y and making cat-like sounds. V14 stated R3 was observed cursing and yelling at R4. V14 could not recall the exact words exchanged between R3 and R4 and did not recall hearing any statements regarding physical harm to R3. V14 stated that her attention was focused on the interaction between R3 and R4 and, therefore, she could not recall who else was present in the dining room. V14 stated before the end of her shift, the situation had de-escalated, and both residents were placed on one-to-one supervision. V14 reported the incident immediately to V1 (Administrator), V5 (Social Services), and V2 (Director of Nursing). V14 stated R3 did not report being struck by R4. V14 conducted a full-body assessment of R3 and did not observe any signs or symptoms of physical assault, including redness, bruising, or bleeding. V14 stated that R3 was not on one-to-one supervision at the time of the incident. V14 stated she did not know who was assigned to supervise R4 when the incident occurred or how the incident happened. V14 stated that R4 was supposed to be monitored and supervised by staff on a 24-hour basis. V14 reported that whenever R3 and R4 encountered one another, they would frequently tease and provoke each other. V14 described R3 as a difficult resident who often did not respond to redirection. V14 stated interactions between the two residents consistently created a tense environment. For that reason, V14 believed R3 should not have been permitted to be in close proximity to R4. V14 stated that when R4 was in the first-floor dining room for meals, R3 should not have been present in the dining room at the same time. V14 further stated that R3 and R4 had histories of aggressive behavior toward staff and other residents.On 6/10/26 at 10:01 AM, a phone interview was conducted with V1 (Administrator) regarding R3 and R4's incident on 5/24/26. V1 stated that staff found R3 and R4 arguing in the dining room and threatening one another. Staff intervened and separated R3 and R4. V1 stated that during the altercation, R3 and R4 stated that they did not like each other and made verbal threats face-to-face. V1 stated that during the one-on-one counseling, R3 stated that he was going to kill R4. The physician was contacted and provided an order to send R3 for a psychiatric evaluation. R3 was also observed cursing and threatening staff while using racial slurs. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	V1 stated that R4 also told staff that he was going to hit and kill both R3 and R6. Due to their threatening behaviors, R3 and R4 were sent to the hospital for evaluation. One resident had a diagnosis of schizophrenia, and the other had a diagnosis of bipolar disorder. V 1 stated R3 and R4 had histories of aggression toward staff and other residents. V1 stated that the R3 and R4 had a history of confrontations with other individuals in the facility and had made threats to kill someone. V1 stated, R4 was supposed to be on one-to-one supervision. However, it was not reported to V1 that R4 had picked up a chair and struck R3. Staff did not witness any physical altercation, and no one reported witnessing R3 being struck by R4 with a chair or walker. V1 stated that both residents had care plans and had a history of making allegations against one another. V1 stated that the reason R4 was on one-to-one supervision was due to a prior physical altercation with R6 in May, for which the facility had previously received a citation. V1 stated that R3's dislike of R4 was influenced by stories provided by R6. V1 further stated that the altercation may have been prevented if the residents had not been in close proximity to one another. Due to their history, R3 and R4 were not supposed to be in the same room at the same time.On 6/10/24 at 10:20 AM, V22 (Licensed Practical Nurse/LPN) stated that the incident between R3 and R4 occurred early in the morning. V22 was informed that R4 had been involved in a verbal altercation with R3. After the incident, R4 approached V22 and appeared angry. V22 stated R4 was on one-to-one supervision at the time. R4 expressed that other residents were not treating him well and stated that if someone punched him, he would punch them back. V22 stated R4 further indicated that he would hit someone in retaliation. V22 described R4's anger as uncontrollable and stated that he was resistant to redirection. R4 reportedly wanted to return to the first floor to fight and could not be redirected from that behavior. Due to his behaviors, R4 was sent to a psychiatric hospital for evaluation and treatment. V22 stated she assessed R4 and he had no injuries or no signs and symptoms of hitting. V22 explained that one-to-one supervision requires a designated staff member to remain with the resident at all times. V22 stated the supervising staff member should not be separated from the resident, even briefly. V22 stated that if R4 had not been left alone by staff, the altercation with another resident may have been prevented.On 6/10/26 at 2:09 PM, V2 (Director of Nursing) stated that residents residing in the facility have the right to remain safe. V2 stated residents involved in behavioral incidents may be placed on one-to-one supervision depending on the circumstances. V2 stated that one-to-one supervision requires the assigned staff member to remain with the resident at all times, 24 hours per day, until the supervision is discontinued or the resident is discharged from the facility. V2 stated that R4 was on one-to-one supervision due to a history of altercations with another resident. The supervision was intended to remain in place until alternative placement could be found for R4. V2 stated that R4 had a history of aggressive behavior toward other residents and had made verbal threats against them. For the safety of other residents, the facility maintained R4 on one-to-one supervision. R3 was not on one-to-one supervision. V2 stated that staff informed her of an incident involving R3 and R4, although she could not recall which staff member provided the information. V2 was informed that R3 and R4 had been yelling and cursing at each other in the first-floor dining room and were subsequently separated. V2 stated that nurses assessed both residents and completed full body assessments. No injuries were noted, and there were no signs or symptoms indicative of a physical assault. V2 stated that both R3 and R4 were transferred to a psychiatric hospital for evaluation due to unpredictable aggressive behaviors toward other residents and staff. V2 reported that no information was received from R6 indicating that R4 had struck R3 or vice versa.Surveyor was unable to contact R3. On 6/10/26 at 1:24 PM, contacted V29 (R3's Family Member) and stated that R3 is currently in the hospital and does not have his direct contact information.Surveyor requested video footage of the R3 and R4's incident on 5/24/26 in the dining room, but V1 and V2 stated there were no video footage recorded since the cameras were not functioning.The facility's policy titled, Your Rights and Protections as a Nursing Home Resident (undated) reads in part: You have the right to be treated with respect, and be free from abuse and neglect.