

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146167	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/26/2025
NAME OF PROVIDER OR SUPPLIER Foster Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2840 West Foster Avenue 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. (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interviews and record reviews, facility failed to follow their policy to protect the resident's right to be free from [A] verbal abuse by a staff member for one [R2] of four residents reviewed for abuse, [B] failed to provide the abuse training to the alleged perpetrator [V6] staff member, and [C] failed to follow their Abuse Prevention Program Policy and report an allegation of abuse within 2 hours of the incident to IDPH (Illinois Department of Public Health) for one [R2] of four residents reviewed for abuse. Findings include: R2 has diagnosis not limited to Hyperlipidemia, Type 2 Diabetes Mellitus, Repeated Falls, Anxiety Disorder, Dysphagia, Major Depressive Disorder, Spinal Stenosis, Cervical Region, Pain, Low Back Pain, Fibromyalgia, Morbid (Severe) Obesity Due to Excess Calories, Generalized Anxiety Disorder. R2's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 15 indicating intact cognitive response. R2's Care Plan in part: R2's assessments reveal factors that may increase R2's susceptibility to abuse. R2 will be treated with respect, dignity, and resides in a facility free of mistreatment. The facility will assure that R2 is in a safe and secure environment, to ensure staff members are available to help and address concerns. Investigate statements/ allegations per facility protocol. R2's progress notes in part: 12/23/25 7:50 AM, Nurse Note: R2 was observed with a new onset of confusion, lethargy, and unable to recognize person, day or time. R2 is usually alert and oriented x4. Received order to send R2 to the emergency department. 12/23/25 at 2:08PM Nurse Note: R2 was admitted to the hospital with admitting diagnosis of altered mental status. On 12/23/25, R2 was sent and admitted to the hospital with a diagnosis of change in mental status. R2 was not available for interview. On 12/23/25 at 11:30 AM, V9 [Clinic Manager] stated, On 10/16/25, between 9AM to 10AM, R2 was in the medical clinic. R2's wheelchair had broken during transport to the medical clinic. R2's escort [V6], V10 [Medical Clinic Office Assistant] and I was at the desk, when V6 was asking if R2 can see the physician past R2's appointment time. I explained the appointment would have to be rescheduled. V6 said R2 had been waiting a long time to receive the appointment, then R2 replied 'No I haven't waited a long time', V6 proceeded and said to R2 'Shut the f_ _k up.' R2 did not say another word, he just looked downward. I then called the nursing facility and spoke with V5 [Office Manger] and V3 [Director of Nursing]. V3 was on speaker phone. I told V5 and V3 exactly what V6 told R2. Neither one [V5, V3] did not have anything to say. I decided to call IDPH, to report the verbal abuse I witnessed. On 12/23/25 at 11:40 AM, V10 [Medical Clinic Office Assistant] stated, I was at the desk when V6 [Escort] was asking if R2 could see the physician, because it took a long time to receive an appointment. When R2 said I haven't been waiting for long time, V6 turn to R2 and said, 'shut the f_ _k up.' R2 did not say another word, R2 got quiet and looked sad. Then V9 called and reported the incident to R2's nursing facility. On 12/23/25 at 1:50 PM, V6 [Escort] stated, I am not a certified nurse assistant. I am an escort. I go out with residents on appointments. I don't remember receiving abuse training. I do not know who the abuse coordinator is. I went out with R2 to his medical appointment in October. That was the day his wheelchair broke. I was at the desk with R2 and two other ladies. I was trying to get R2 seen by the physician while we were there, because it took a long time waiting to receive an appointment. I did not curse at R2. While I was speaking, R2 did cut me off, but I did not curse at R2. On 12/23/25 at 2:00 PM V5 [Office Manger], stated, I received a phone call from V9 [Medical Clinic Manager] and asked when R2's transportation will be there for pick up. Also, V9 said that V6 was rude to R2. That's all V9 said to me, she did not say how or what V6 did to R2. I did not believe V9, because I never heard V6 curse. Surveyor asked V5, why did she say she never heard V6 curse, did V5 say V6 cursed at R2? V5 stated, Oh yeah, I just told on myself, okay. V9 did say she heard V6 curse at R2 saying 'shut the f_ _k up'. I did not tell V3 [Director of Nursing], but I told V1 [Administrator] immediately. But V1 and I knew V6 did not curse at R2, because she is a good person, and we never heard V6 curse before, V1 and I did not believe V9. On 12/23/25 at 3:00 PM, V1 [Administrator] stated, V5 kept me informed about R2's broken wheelchair and transportation issues. V5 did not report R2 was verbally abused by V6 at his medical appointment, but I take full responsibility leave V5 and V3 out of this. I am the human resource director. I cannot locate V6's abuse training during orientation. I must have misplaced the abuse training. If I was made aware of the allegation, V6 would have been suspended immediately, reported to IDPH, and investigation would have occurred. On 12/24/25 at 10:10 AM, V1 stated [during telephone conversation], I called the hospital and spoke with R2. I asked R2 if V6 cursed at him, R2 said he did not know who V6 was. R2 was admitted to the hospital for altered mental status. Also, V5 told me she was confused during the interview and she mistakenly said she told me V6 cursed at R2. On 12/26/25 at 11:30 AM V1 stated. The</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review the facility failed to ensure a resident was properly assessed for the sizing of a wheelchair and failed to follow their Accident Incident/Fall Reporting Policy for one (R2) of three residents reviewed for wheelchair use. Findings Include: R2 has diagnosis not limited to Hyperlipidemia, Type 2 Diabetes Mellitus, Repeated Falls, Anxiety Disorder, Dysphagia, Major Depressive Disorder, Spinal Stenosis, Cervical Region, Pain, Low Back Pain, Fibromyalgia, Morbid (Severe) Obesity Due to Excess Calories, Generalized Anxiety Disorder. R2's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 15 indicating intact cognitive response. R2's Care Plan document in part: Problem: R2 is High risk for falls r/t (related/to) gait/balance problems. Interventions: Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter remove any potential causes if possible. Educate resident/family/caregivers/IDT (interdisciplinary team) as to causes. Problem: Resident has Alteration in mobility/ Transfer R/T fibromyalgia, repeated falls, weakness and Pain. On 12/23/25 at 11:15 AM V9 called the surveyor and said when R2 came to the hospital the care giver (V6 Escort Provider) said R2 fell out of the van when the driver made a sharp turn. R2's wheelchair had a broken armrest, wheel and the wheelchair was unstable so we could not move R2 inside. It was as if the wheelchair was too small and R2 needed a larger wheelchair. V7 (Activity Director/Certified Nurse Assistant) arrived with a wheelchair that was the same size. I am concerned with R2's wellbeing and R2 waited 8 hours before they sent a van to pick R2 up. Both a coworker and I witnessed it. The facility came on 2 separate occasions, with 2 separate rides and with the wheelchair that was too small. V6 stated the resident fell in the van when they were trying to get him out of the van. When R2 arrived at the clinic a code blue was called. R2 told me he fell immediately after they left the facility, was not strapped in and was laying sideways for the entire ride on the van's floor. My concern was R2 had fallen, and they let R2 stay on the floor of the van. I made the facility aware of the situation around 9-10 am and they were dismissive and argumentative. On 12/23/25 at 11:37 AM V10 (Office Assistant) said R2 was here 5-6 hours later when the facility finally picked R2 up. On 12/23/25 at 10:17 AM upon entering R2's room surveyor observed a large wheelchair located near the foot of R2's bed with damage to the left armrest cushion. R2 had been transferred to the hospital due to altered mental status. On 12/23/25 at 10:17 AM R3 stated R2 said he used to have a different wheelchair. The wheelchair that R2 had was like that one near R2's bed but it was just smaller. On 12/24/25 11:00 AM V16 (Certified Nurse Assistant) stated I was one of the people that cleaned R2 up, put on his clothes and helped put him in the wheelchair. I don't know if they had to change R2 out of the chair because it did not fit on the transportation van. R2 usually stays in bed because he cannot stand and does not have weight bearing for his ankles. On 12/23/25 at 12:49 PM When asked did she escort R2 to his appointment on 10/16/25 V6 (Escort Provider) responded, I pushed R2 to the transportation van. R2 changed wheelchairs into a smaller wheelchair because the big boy wheelchair would not fit on the van's transportation wheelchair ramp. R2 mentioned they gave him a reduced wheelchair, smaller wheelchair so it could fit on the ramp into the medical van. The driver came out and pushed R2 up the ramp. The floor in the van was a plain floor with straps on the side, inside the spokes of the wheels of the wheelchair. I am not sure if the driver strapped R2 in because I was outside of the van and I was not paying that close of attention. As far as I am concerned the driver did everything I could have sworn. There was a long bench seat in the van, and I can't tell you if R2 was strapped in because I was sitting next to the driver. R2 is a big guy. The driver said if you like you can sit in the front passenger seat. I did not sit in the back on the bench seat because it was not enough room. I am glad I was not back there because R2 would have fell on me. The driver made a left turn and R2 fell. The wheelchair tilted sideways, and the wheels were in the air. R2 fell leaning towards the bench seat. I told the driver to pull over. The driver opened the door and R2 was facing the door behind the driver. The driver could not get R2 up and said he needed some help. R2 is alert and oriented x3. When we get to the clinic they came out and 911 was called. 911 used a sheet and blanket to get R2 up. R2 was uncomfortable because he was used to his own wheelchair. The wheelchair left wheel was bent in when R2 was tilted, that is why the driver could not get R2 back. The spinal people said you cannot push R2 to his appointment because they said it was unsafe to go to R2's appointment and they cancelled his appointment. The fire department, they were all over R2 and I was back where I could not see R2's position. I don't know how they got R2 out of the van. 911 put R2 back in the broken wheelchair, R2 was still sitting in his broken wheelchair, and we were sitting there forever waiting on another wheelchair. I called V1 (Administrator) to let her know the fire department handled that</p>		