STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145312	A. Building B. Wing	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Symphony Northwoods	2250 Pearl Street Belvidere, IL 61008

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22499 Based on interview and record review the facility failed to identify and treat a pressure ulcer for a resident dependent on staff for care. This failure resulted in R1's pressure ulcer to his right heel not being identified until it was necrotic and unstageable on 3/18/24. This applies to 1 of 3 residents (R1) reviewed for pressure ulcers in the sample of 5. The findings include: R1's Face Sheet shows that he was admitted to the facility on [DATE] with diagnoses including Type 2 Diabetes, Atrial Fibrillation, Cellulitis of the Left Lower Limb, Lymphedema, Muscle Weakness, Acute Cystitis and Morbid Obesity. R1's Progress Notes dated 3/17/24 state, Necrotic tissue on bottom of Right heel surrounded by slough. Resident Unaware of wound. Wound care nurse notified. NP notified. POA updated. Foam boots applied. R1's Progress Notes dated 3/18/24 state, Resident was notified by staff regards new skin alteration to left heel, upon assessment noted unstageable to right heel, wound bed necrotic, no exudate noted, resident denies any pain to right heel but complains of pain to right leg. Writer notified NP (V4), per (V4) orders to send out to ER for further evaluations and to rule out DVT. On 6/3/24 at 11:15AM V3 (LPN-Wound Nurse) stated, He came from the hospital. He was resistive to all care, pericare, therapy. On Monday (3/18) morning when I came in he had a new skin alteration, he refused to wear the boots, refused to have heels elevated on a pillow because he said it was uncomfortable. I notified (V4) and she said to send him out. I was doing the dressing on his legs prior to that and they were weeping. I changed the dressings on Monday/Wednesday and Friday. He would not allow anymore than that, he said he didn't need it. I am here Monday - Friday-. When I saw the wound on the heel (V4) and I wanted to make sure it was not a DVT. I was doing the leg treatments so this had to have happened over the weekend. I do the wound assessments weekly. He tried to reposition himself but he wouldn't let us reposition him. He was admitted with chronic cellulitis and was always in supine position. He refused boots or pillows. (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 0686 Level of Harm - Actual harm Residents Affected - Few	On 6/3/24 at 1:32 PM R1 stated, The heel on my right foot got a terrible pressure sore on it that I am still working on healing today (at another facility). I looked at all my records from when I was in the hospital the first time and there was no mention of a pressure sore so I know I got it there. I was able to move my leg but every morning I would wake up in a puddle on the bed because my legs were weeping so much. I begged for a week for wound care to come and take care of my legs. I never had any boots until about 1/2 an hour before I left. Finally when they noticed my heel was black they sent me out right away. On 6/3/24 at 1:24 PM V5(RN) stated, He had been complaining of right leg pain. He had had therapy earlier and (V7-CNA) was getting him ready for bed. He complained of right heel pain. She asked me to come look at it. It was black and full of necrotizing tissue. I was unsure if anyone knew about it so I contacted wound care, the MD and the POA. There was no other documentation about it so I guess no one had noticed it. I never had any issues with him. I heard he was sometimes non-compliant with therapy during the day but I didn't try to get him to therapy. He was cooperative and took his medications . On 6/3/24 at 2:00PM V4 (Nurse Practitioner) stated, I didn't know anything about his heel. He never complained of pain to his heel, the pain was in his hip. The wound nurse called me and said it was black and it wasn't there before so I told her to send him out . With the heel, I wanted to make sure it wasn't circulatory, make sure it wasn't a DVT. On 6/3/24 at 2:30 PM V7 (CNA) stated, He had his call light on and I went in there and he said his leg was hurting- in the groin area. I put him in bed and then a little while later he wanted to get up to the chair and use the restroom again so I helped him and he said his heel was hurting. I looked at his foot and it was all blackish in color. This was my first day on the short hall so I had not really worked with his before. We are supposed to do skin checks on shower days and then document it on the shower sheet. I reported it to the nurse and she came and looked at it. R1's Wound Assessment Details Report dated 3/18/24 shows that R1 had Unstageable Necrotic, hard, Firm, Adherent- 100% Facility Acquired Pressure Ulcer to his right heel. This form shows the wound measured 5.5 x 7.0 cm. R1's Braden Scale for Predicting Pressure Ulcer Risks dated 2/10/24 shows that he scored a 15 (15-18= At Risk) R1's Physician's Order Sheet dated 2/10/24- 3/18/24 shows no orders for heel lift boots or off-loading of R1's heels. R1's Care Plan dated 3/8/24 states, Potential/At Risk for alteration in skin integrity due to risk factors associated with diabetes The interventions include: Reposition/shift weight at frequent intervals to resident's comfort, Remind/ Assist Resident to reposition frequently and Check skin daily. R1's Hospital Discharge Summary dated 3/18/24- 3/28/24 shows one of R1's admitting and discharge diagnoses as Decubitus Ulcer of right foot- s/p excisional debridement on 3/24/24. This form states, He will be weight bearing as tolerated for transfers and short distances attempting to avoid pressure to the right heel. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The facility policy entitled Skin Management Program dated 8/23/23 states, It is the policy of the facility that a guest does not develop pressure injury unless clinically unavoidable. Guests with wounds and/or pressure injury and those at risk for compromise are identified, assessed and provided appropriate treatment to promote healing. Ongoing monitoring and evaluation are provided to ensure optimal guest outcomes. A Braden Scale will be completed upon admission, weekly for 4 weeks, quarterly and with a significant change of status by a licensed nurse to determine the risk of pressure injury development. Appropriate preventative measures will be implemented on guests identified as risk (a score of 18 or less on the Braden Scale) and the interventions documented on the care plan.