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	06/11/2025

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 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 to ensure a resident with acute delusions was monitored and supervised. This applies to 1 of 3 residents (R1) reviewed for safety in the sample of 3. The findings include: R1's face sheet shows she is a [AGE] year old female with diagnoses including unspecified psychosis, cerebral infarction, hypertension, adjustment disorder with depressed mood, weakness and unsteadiness on feet. R1's face sheet shows she was admitted to the facility on [DATE] from the hospital. On 6/11/25 at 9:57 AM, R2 (R1's roommate) said on Friday night (6/6/25), R1 woke up screaming after the nurse woke her up to give her medications. R1 was screaming your not my nurse, your not my nurse. R1 also alleged the nurse put something on her wrist and was hurting her (blood pressure cuff). R1 kept yelling and finally a male nurse came in V3 (Assistant Director of Nursing-ADON) and tried to calm her down. R1 was looking out the window yelling to call 911, and yelling out for Michael call 911. R2 said V3 sat in the room for a while until R1 calmed down. She said she did not witness any staff hurt R1. R2 said this was the 2nd night in a row she could not sleep because of R1 was not right during the night. R1 was fine during the day, we would talk, but during the night she was not right, not humane. Maybe she was sundowning, she was confused and a different person during the night. On 6/11/25 at 11:31 AM, V3 (ADON) said he came in to cover the first half of the 3rd shift due to a call off. He said sometime after 12:00 AM, he heard yelling from R1's room. R1 was picking up the blinds saying her husband (V7) was outside. There was a car outside, but it was not her husband. V3 said he encouraged R1 to go back to sleep. R1 was alert and oriented and he thought maybe she was not getting enough rest. (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	On 6/11/25 at 11:11 AM, V4 (RN) said she came in at 2:00 AM to 6:00 AM and split the shift with V3. It was reported, R1 had behaviors of agitation but was re-directable. R1 was awake when she started her shift. R1 was placed at the nurses station so she could be supervised about 2:30-3:00 AM. R1 was pleasant when she was at the nurses station. She saw R1 last around 4:45 AM to 5:00 AM at the front lobby near the nurses station. Around 5:15 AM, V5 (Certified Nursing Assistant-CNA) came up to me if I had seen R1. She told V5 to check all the rooms and the basement and V6 (CNA) checked the rooms upstairs. V4 said she went outside to look for her and did not see her. She went back in the building and V5 and V6 reported they did not locate R1. V4 said she went back outside to the end of the driveway and saw R1 in her wheelchair down the street on the sidewalk. She assisted R1 back to the building, notified the POA and V2 (Director of Nursing). R1 told her she was trying to leave because she did not want to be at the facility anymore and reported an allegation of abuse. She said she was being abused by the RN who runs this place. R1 said it was a male nurse with glasses. R1 was very agitated, tearful and delusional. R1 remained with staff until V7 (R1's husband) showed up to the facility. R1 was placed at the nurses station for monitoring, V5 (CNA) got up to answer a call light and when she returned R1 was gone. We initiated a code gray and R1 was found shortly after with no injury. On 6/11/25 at 11:43 AM, V5 (CNA) said on 6/7/25, R1 was placed at the nurses station between 2:30 AM -3:00 AM. We were checking on her every 15 minutes and kept her at the nurses station. She got up to answer a call light before 5:00 AM and assisted a resident with cares and when she returned back to the nurses station, R1 was not at the nurses station. She asked V4 (RN) if she had seen R1 and then they started searching for R1 in the building. They searched every room, downstairs and did not locate R1. When she looked outside V4 (RN) was with R1 and we got R1 back in the building. R1 was in her wheelchair fully dressed when she left the building. She remained with R1 until V7 (R1's husband) arrived. V5 said R1 was calm whle at the nurses station and did not show any signs of elopement. On 6/11/25 at 12:04 PM, V7 said on 6/7/25, he received a call about 5:30 AM that R1 went outside in her wheelchair down the street from the facility. He said when he arrived to the facility about 15 minutes and R1 was very agitated and wanted to leave the facility. She alleged the nurse had slammed her and they were trying to hurt her roommate. She also alleged they put something on her wrist. V7 said he took R1 home and she has been fine since. Recently they made changes to her antipsychotic medications before her admission and she had a recent urinary tract infection. V7 said when R1 gets sick she gets delusional and maybe with the changes in her psych meds could have caused the delusions. V7 said he was R1 for most of the day on 6/6/25 and left the facility about 7:00 PM and R1 was fine. On 6/11/25 at 10:54 AM, V2 (Director of Nursing-DON) said she was notified about 5:15 AM, they could not locate R1. V4 (RN) found R1 outside on the sidewalk about 130 feet away from the facility. Prior to that R1 was at the nurses station being monitored for acute behaviors and V5 (CNA) got up to answer a call light and when she returned R1 was not at the desk. They searched for R1 in the facility and found R1 outside within 30 minutes. She notified V7 (R1's husband) and he went to the facility right away. R1 alleged allegation of abuse during this time and reported to V7 they would notify the police. V7 declined for the police to respond and took her home. R1 was a recent admit from the hospital with UTI, she was cognitively intact, and did not display exit seeking behaviors prior. There was a referred for psych prior and a UA was ordered due the recent behavior. They followed our protocol when they could not locate a resident and she was found with no injury. R1 had not shown exit-seeking behaviors prior. She would expect the staff to supervise a resident with acute cognitive changes. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Community Skills Determination form dated 5/27/25 shows she is alert, oriented, and free from confusion allowing her to be considered for independent pass privileges. The facility's Elopement Event Policy revised 8/22 states, The facility has a plan in case of an elopement of a resident from the facility. This enables the missing resident to be found as quickly as possible and to maintain the residents safety, dignity and privacy. If a resident is discovered missing: alert the nursing supervisor, staff on the unit should perform a thorough search of the unit/area. Notify the Administrator/DON immediately and announce facility code overhead. Immediately begin a thorough search of the facility grounds .when the resident is found the DON or administrator will notify the residents representative and police .