

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145312	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/10/2025
NAME OF PROVIDER OR SUPPLIER  Symphony Northwoods		STREET ADDRESS, CITY, STATE, ZIP CODE  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 0580  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.  (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 0580</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 inform a resident's representative of new a injury/bruise found to a resident's shoulder for 1 of 1 residents (R2) reviewed for a resident change in condition in the sample of 5. The findings include:A facility Incident report dated 9/6/25 showed on 9/5/25 at 4:20 AM, facility staff discovered new bruising to R2's left upper arm. The facility notified R2's hospice agency which subsequently ordered an X-ray of R2's left arm. An X-ray of R2's left arm was performed in the facility which showed R2's left shoulder was dislocated. The report showed R2 was sent to a local hospital on 9/6/25 for an evaluation of her shoulder dislocation. R2's progress note dated 9/5/25 showed at 4:20 AM, facility staff discovered new bruising to R2's left shoulder. The note showed R2's hospice agency was notified of the new bruise on 9/5/25 by facility staff. The note showed no documentation facility staff notified V8 (R2's Power of Attorney/POA) of R2's new bruising. A physician order dated 9/5/25 at 1:23 PM showed an X-ray of R2's left shoulder was ordered/obtained by V14 (R2's Hospice Nurse) after R2 was assessed by V14. R2's progress notes dated 9/5/25 from 4:20 AM to 9/6/25 at 9:30 PM were reviewed and showed no documentation facility staff attempted to notify V8 (R2's POA) of the new bruising found on R2's left shoulder. Progress notes showed V8 was contacted by facility staff about a room change for R2 but not informed of the changes noted to R2's left shoulder. R2's progress note dated 9/6/25 at 9:40 PM showed the facility was notified, by R2's hospice agency, of R2's X-ray results which showed her left shoulder was dislocated. The note showed the hospice agency had notified V8 (R2's POA) of R2's X-ray results. R2 was sent to a local hospital for an evaluation due to her injury.On 9/10/25 at 10:37 AM, V8 (R2's POA) stated he upset because the facility never called him to inform him of the new bruising to R2's shoulder or that an X-ray had been ordered of R2's left shoulder. V8 stated, No one called me on September 5th or 6th to tell me about her shoulder. Someone called me on September 5th to tell me they were moving (R2) to a different room, but they didn't say anything to me about her shoulder. The first I heard anything about it was when someone from hospice called me that night (9/6/25) to tell me her shoulder was dislocated, and they needed to send her to the hospital.On 9/10/25 at 10:48 AM, V10 RN stated she was notified of new bruising to R2's left shoulder by V9 CNA on 9/5/25. V10 she immediately went to assess R2 and found R2's left upper arm to be purple in color and warm to the touch. V10 stated she notified R2's hospice agency of R2's new bruise. V10 stated she did not notify V8 (R2's POA) of the new bruising noted to R2's shoulder. On 9/10/25 at 11:15 AM, V3 Assistant Director of Nursing (ADON) stated he was notified of the new bruising to R2's left shoulder on the morning of 9/5/25. V3 stated when he observed R2's shoulder on that morning, he noted a new. large bruise to R2's left upper arm. V3 stated he did not notify V8 (R2's POA) of the new bruising noted to R2's shoulder. On 9/10/25 at 1:00 PM, V2 Director of Nursing (DON) stated she examined R2's left shoulder on 9/5/25 after she was notified of the new bruising. V2 stated she noted a large bruise to R2's left upper arm. V2 stated she did not contact V8 (R2's POA) to notify him of R2's new bruising. V2 DON stated facility staff are to immediately report any changes in a resident's condition to the resident's POA/representative as soon as possible.The facility's Responding to an Acute Change of Condition policy dated August 2025 showed, Residents who experience an acute change in condition will have their condition monitored, the attending physician notified, and the responsible party informed when the condition changes and as follow up actions occur. GOAL . To ensure that the responsible party is notified of a residents change in condition as soon as practical, and plan of care is updated .</p>		

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F 0684  Level of Harm - Actual harm  Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals.  (continued on next page)

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F 0684  Level of Harm - Actual harm  Residents Affected - Few	<p>Based on interview and record review the facility failed to assess, intervene and implement treatments in a timely manner for a resident (R2) found to have a new injury/bruising to her left shoulder which resulted in a delay in the diagnosis and treatment of R2's left shoulder dislocation. This failure applies to 1 of 5 residents (R2) reviewed for the necessary care and services in the sample of 5. The findings include: A facility Incident report dated 9/6/25 showed on 9/5/25 at 4:20 AM, facility staff discovered new bruising to R2's left upper arm. The facility notified R2's hospice agency which subsequently ordered an X-ray of R2's left arm. An X-ray of R2's left arm was performed in the facility which showed R2's left shoulder was dislocated. The report showed R2 was sent to a local hospital on 9/6/25 for an evaluation of her shoulder dislocation. The report showed hospital recommended surgical intervention to reposition the shoulder; however, V8 (Power of Attorney/POA for R2) declined surgical intervention. R2's hospital records dated 9/6/25 showed a repeat X-ray of R2's left shoulder was performed which showed R2's left shoulder was dislocated with a possible glenoid (shoulder bone) fracture. R2 was discharged back to the facility on 9/6/25, on hospice, with orders for R2's left arm to be kept in a sling for comfort and conservative management of R2's shoulder dislocation. R2's current care plan showed R2 was severely cognitively impaired and primarily nonverbal due to her diagnosis of Alzheimer's disease. R2 was unable to verbalize her needs. R2 was dependent on staff for all cares. R2 was unable to move on her own. R2 required two staff members to safely reposition her in bed. R2 was on hospice. R2's progress note dated 9/5/25 showed at 4:20 AM, facility staff discovered new bruising to R2's left shoulder. The note showed R2's hospice agency was notified of the new bruise on 9/5/25. The note showed no documentation facility staff notified R2's physician or nurse practitioner of the R2's new bruising. The note showed no documentation that facility staff attempted to obtain a physician order to X-ray R2's shoulder. A physician order dated 9/5/25 at 1:23 PM showed an X-ray of R2's left shoulder was ordered/obtained by V14 (R2's Hospice Nurse) after R2 was assessed by V14. R2's progress notes dated 9/5/25 from 4:20 AM to 9/6/25 at 9:30 PM were reviewed and showed no documentation of facility staff attempting to notify R2's physician or nurse practitioner of the new bruising to R2's shoulder. The progress notes showed no documentation of staff reassessing R2's left shoulder bruising at any time after the bruising was found. The progress notes showed no documentation of staff attempting to contact the facility's mobile X-ray company to ensure the X-ray of R2's left shoulder was completed as soon as possible. R2's progress note dated 9/6/25 at 10:21 AM showed an X-ray was completed in the facility of R2's left shoulder; over 24 hours after the new bruising/injury to R2's left arm was found by staff. R2's progress note dated 9/6/25 at 9:40 PM showed the facility was notified, by R2's hospice agency, of R2's X-ray results which showed her left shoulder was dislocated. R2 was sent to a local hospital for an evaluation due to her injury. On 9/10/25 at 10:48 AM, V10 RN stated she was notified of new bruising to R2's left shoulder by V9 CNA on 9/5/25. V10 stated she immediately went to assess R2 and found R2's left upper arm to be purple in color and warm to the touch. V10 stated she did not complete a range of motion assessment on R2's left arm. V10 stated she notified R2's hospice agency of R2's new bruise. V10 stated she did not notify R2's physician or nurse practitioner of the changes noted to R2's shoulder. V10 stated, I notified hospice. They were coming in to see her later that day (9/5/25). I just assumed hospice would follow up on her shoulder and get an X-ray if she needed it. On 9/10/25 at 11:15 AM, V3 Assistant Director of Nursing (ADON) stated he was notified of the new bruising to R2's left shoulder on the morning of 9/5/25. V3 stated when he observed R2's shoulder on that morning, he noted a new, large bruise to R2's left upper arm. V3 stated he did not contact R2's physician or nurse practitioner to inform them of the bruise and/or obtain an order for an X-ray because we were just kind of waiting on direction from her hospice. V3 stated facility staff are to notify a resident's physician or nurse practitioner immediately with any changes in resident condition. When asked why the facility did not order any X-ray of R2's shoulder themselves and why it took over 24 hours for R2's X-ray to be completed, V3 stated, I believe we could have ordered the X-ray ourselves if we had contacted the physician. I don't know how the X-ray was ordered by hospice. I don't know why it took so long to get it. On 9/10/25 at 11:19 AM, V14 (R2's Hospice Nurse) stated she was notified of the new bruising to R2's shoulder on 9/5/25. V14 came to the facility on 9/5/25 to assess R2. V14 stated, I found bruising to (R2's) left lateral arm and posterior shoulder area. (R2) didn't appear to be in pain. It was her bath day. My hospice CNA went to bathe her and called me immediately. She said that something was wrong with (R2's) shoulder because she said (R2's) shoulder was floppy and seemed unstable. That is when I ordered the X-ray. When asked if she</p>		

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F 0689  Level of Harm - Actual harm  Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.  (continued on next page)

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F 0689  Level of Harm - Actual harm  Residents Affected - Few	<p>Based on observation, interview and record review the facility failed to care for a resident (R2) in a safe manner which resulted in R2 sustaining a left shoulder dislocation. The facility failed to ensure a resident (R2) was safely repositioned in bed, as directed per the resident's care plan. These failures apply to 1 of 5 residents (R2) reviewed for resident safety and supervision in the sample of 5. The findings include: A facility Incident report dated 9/6/25 showed on 9/5/25 at 4:20 AM, facility staff discovered new bruising to R2's left upper arm. The facility notified R2's hospice agency which subsequently ordered an X-ray of R2's left arm. An X-ray of R2's left arm was performed in the facility which showed R2's left shoulder was dislocated. The report showed R2 was sent to a local hospital on 9/6/25 for an evaluation of her shoulder dislocation. The report showed hospital recommended surgical intervention to reposition the shoulder; however, V8 (Power of Attorney/POA for R2) declined surgical intervention. R2's hospital records dated 9/6/25 showed a repeat X-ray of R2's left shoulder was performed which showed R2's left shoulder was dislocated with a possible glenoid (shoulder bone) fracture. The X-ray results showed no findings of osteopenia or osteoporosis. R2 was discharged back to the facility on 9/6/25. R2's current care plan showed R2 was severely cognitively impaired and primarily nonverbal due to her diagnosis of Alzheimer's disease. R2 was unable to verbalize her needs. R2 was dependent on staff for all cares. R2 was unable to move on her own. R2 required two staff members to safely reposition her in bed. R2 was on hospice related to her diagnosis of Alzheimer's disease. R2's progress note dated 9/5/25 showed at 4:20 AM, facility staff discovered new bruising to R2's left shoulder. The note showed the area of bruising to R2's left shoulder was warm to the touch. R2 was noted to be sleeping, looks comfortable. The note showed R2's hospice agency was notified of the new bruise on 9/5/25. A physician order dated 9/5/25 at 1:23 PM showed an X-ray of R2's left shoulder was ordered. R2's progress note dated 9/6/25 at 10:21 AM showed an X-ray was completed in the facility of R2's left shoulder. R2's progress note dated 9/6/25 at 9:40 PM showed the facility was notified, by R2's hospice agency, of R2's X-ray results which showed her left shoulder was dislocated. R2 was sent to a local hospital for an evaluation due to her injury. On 9/10/25 at 8:30 AM, R2 was asleep in a high-back wheelchair on the facility's memory care unit. A sling was noted around R2's left arm. The sling held her arm in place, close to R2's chest. On 9/10/25 at 11:04 AM, V11 Certified Nursing Assistant (CNA) stated she provided cares to R2 from 2 PM-10 PM on 9/4/25. V11 stated R2 had no bruising to her left shoulder during that time. V11 stated R2 did not have any falls or sustain any injuries during her shift on 9/4/25. On 9/10/25 at 10:28 AM, V9 CNA stated he provided cares to R2 on 9/4/25, from 10 PM - 6 AM. V9 stated from 10 PM on 9/4/25 to approximately 3 AM on 9/5/25, he repositioned R2 in bed and provided her with incontinence care, by himself, two different times. V9 stated R2 was nonverbal and totally dependent on staff for cares but that he always provides these cares, including bed mobility and repositioning, to R2 by himself. V9 stated R2 was dressed in a sweater when he provided cares to R2 from 10 PM-3AM so he was not able to visualize her left shoulder during that time. V9 stated around 4 AM on 9/5/25, he again provided cares to R2, by himself, which included repositioning her in bed, incontinence care, and getting her dressed. R2 stated, When I took her sweater off, I noticed her (left) shoulder was bruised and swollen. It looked abnormal. V9 stated R2 did not appear to be in pain and was not wincing or crying with movement of her left arm. V9 stated he immediately reported the new bruise to V10 Registered Nurse (RN). V9 stated R2 had no falls or injuries while being cared by V9. V9 stated, I don't know what happened to her. I just assumed something happened to her when someone was moving her or removing her shirt. On 9/10/25 at 10:48 AM, V10 RN stated she was notified of the new bruising to R2's left shoulder by V9 CNA on 9/5/25. V10 she immediately went to assess R2 and found R2's left upper arm to be purple in color and warm to the touch. V10 stated R2 did not appear to be in pain as V10 had administered hospice pain medications to R2 one hour prior. V10 stated she had no idea what caused the injury to R2's arm stating R2 was unable to move her extremities on her own. V10 stated she notified R2's hospice agency of R2's new bruise. V10 stated she did not notify R2's physician, nurse practitioner, or V8 (R2's POA) of the changes noted to R2's shoulder. On 9/10/25 at 11:19 AM, V14 (R2's Hospice Nurse) stated she was notified of the new bruising to R2's shoulder on 9/5/25. V14 came to the facility on 9/5/25 to assess R2. V14 stated, I found bruising to (R2's) left lateral arm and posterior shoulder area. (R2) didn't appear to be in pain. It was her bath day. My hospice CNA went to bathe her and called me immediately. She said that something was wrong with (R2's) shoulder because she said (R2's) shoulder was floppy and seemed unstable. That is when I ordered the X-ray. V14 stated R2 was</p>		