

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  10/23/2024
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)
<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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34314</p> <p>Based on observation, interview and record review the facility failed to ensure a non-pressure wound dressing was changed per physician orders. This applies to 1 of 18 residents (R83) reviewed for skin conditions in the sample of 18.</p> <p>The findings include:</p> <p>R83's face sheet list her diagnoses to include: local infection of the skin and subcutaneous tissue, cellulitis of left lower limb and chronic embolism and thrombosis of unspecified deep veins.</p> <p>On October 21, 2024 at 9:38 AM, R83 stated, she has a wound on her foot. The dressing hadn't been changed all weekend. The dressing on the top of her left foot was dated October 18, 2024.</p> <p>R83's wound care evaluation and management summary dated October 18, 2024 by the wound care doctor shows, non-pressure wound of the left dorsal foot. Continue treatment dressing plan: Cleanse with dakins solution, apply mupirocin topical with calcium alginate, cover with gauze island dressing. Change daily.</p> <p>R83's treatment administration record for the month of October 2024 shows, no treatment orders for her left foot wound since October 13, 2024 besides a PRN (when needed) dressing change. No one has signed out the PRN order since it was ordered on October 5, 2024.</p> <p>On October 23, 2024 at 10:17 AM, V3 Wound Care Nurse (WCN) stated, she noticed on Monday (October 21, 2024) the dressing wasn't changed. She had talked with the nurse, who said, she didn't change the dressing because there was no order to change the dressing. V3 WCN stated, she forgot to put the orders in on Friday (October 18, 2024) when the wound care doctor was there. The dressing should have been changed every day.</p> <p>R83's care plan dated August 19, 2024 shows, Focus: Alteration in skin integrity- resident non-pressure wound. Site (left dorsal foot), left lower leg factors that inhibit wound healing: CHF (congestive heart failure). Interventions: Treat as ordered by physician.</p> <p>R83's Minimum Data Set, dated dated dated [DATE] shows, she is cognitively intact.</p> <p>(continued on next page)</p>

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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's physician's orders policy dated October 1, 2021 shows, General: It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. The safety of residents, staff and visitors is of primary importance. The purpose of this policy is to provide guidance for licensed nurses and licensed therapist to accurately document physician and provider orders as determined by the licensee's Scope of Practice.</p> <p>The facility's skin care prevention policy last review date 10/16 shows, General: All residents will receive appropriate care to decrease the risk of skin breakdown.</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>40085</p> <p>Based on interview and record review the facility failed to identify pressure injuries prior to a stage 3 for a resident at risk for pressure with a history of pressure (R1). This failure resulted in a delay in assessing and obtaining treatment orders to prevent pressure injuries from worsening for R1. The facility failed to ensure pressure interventions were in place for a resident with a left heel pressure injury (R72). This applies to 2 of 5 residents (R1, R72) reviewed for pressure injuries in the sample of 18.</p> <p>The findings include:</p> <p>1.) R1's self-care deficit care plan initiated on 6/5/23 shows R1 requires extensive to total staff dependence with incontinence care, personal hygiene, bed mobility, and transferring.</p> <p>R1's skin integrity care plan initiated on 6/29/24 and revised on 9/27/24 shows she is at risk for impaired skin integrity due to cognitive impairment, immobility and nutrition. The care plan identified that R1 currently has pressure injuries to her left buttock, left hip and left shoulder.</p> <p>R1's Pressure Risk Assessment (Braden scale) completed on 8/12/24 by V12 (former Wound Care Nurse) shows R1 scored a 12 and is at high risk for pressure. The assessment shows that skin should be observed and assessed regularly.</p> <p>A Wound Evaluation and Management Summary completed by V7 (Wound Care Physician) on 9/13/24 shows R1 had a stage 3 pressure injury to her left hip which was healed on 9/13/24. The summary does not show any additional pressure injuries for R1 on 9/13/24.</p> <p>A Wound Care noted completed on 9/21/24 shows that R1 was assessed head to toe and had no acute skin alterations.</p> <p>A nursing progress notes for R1 completed by V13 (LPN) on 9/24/24 states, This nurse observed an open skin area to the hip on the resident. Open sore to hip dark discolored area in center, beefy red tissue surrounding. Acute skin alteration noted to right/left buttocks. Area assessed and foam dressing per wound care nurse.</p> <p>A Wound Assessment Details Report for R1 completed on 9/25/24 by V12 (former Wound Care Nurse) shows R1 had the following new pressure injuries identified:</p> <ol style="list-style-type: none"> <li>1. Right Buttock- Stage 2 measuring 1.00 cm. (Centimeters) x 1.00 cm x 0.10 cm. (LxWxD/length width and depth)</li> <li>2. Left Buttock- Stage 2 measuring 1.0 cm. x 1.5 cm. 10 cm.</li> <li>3. Left Buttock- unstageable measuring 0.5 cm. x 0.5 cm. x unknown depth</li> </ol> <p>(continued on next page)</p>		

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F 0686  Level of Harm - Actual harm  Residents Affected - Few	<p>4. Right Trochanter (hip)- unstageable measuring 1.50 cm. x 3.40 cm. x .10 cm. this wound is described as 80% pink or red tissue with non-granulating to the skin and 20% of the wound bed necrotic (dead tissue). The picture on the wound assessment clearly shows the black center of the wound bed.</p> <p>5. Right hip- Stage 1 measuring 7.00 cm. x 5.00 cm. x 0.00 cm.</p> <p>6. Left Shoulder- Stage 1 measuring 3.00 cm. x 3.00 cm. x 0.00 cm.</p> <p>On 9/27/24 V7 (Wound Care Physician) saw R1 and documented the following pressure injuries with his revised/current stages and additional wounds identified.</p> <p>1. Left hip a full thickness pressure injury (no left hip pressure injury was documented by V12 on 9/25/24) identified as a stage 3 measuring 3.0 cm x 1.9 cm. x 0.2 cm. This wound is described as having 20% thick adherent devitalized necrotic tissue to the wound bed that required debriding and removal on 9/27/24 by V12, and 20% slough tissue with 60% viable tissue.</p> <p>2. Left lower medial buttock a full thickness pressure injury a stage 3 measuring 1.0 cm. x 0.6 cm. x 0.2 cm. this wound also required debridement by V12 on 9/27/24.</p> <p>3. Left upper medial buttock a full thickness pressure injury a stage 3 measuring 3.0 cm. x 1.1 cm x 0.2 cm.</p> <p>4. Right upper medical buttock partial thickness pressure injury a stage 2 measuring 0.5 cm. x 0.5 cm. x 0.10 cm.</p> <p>5. Right lower buttock partial thickness pressure injury a stage 2 measuring 1.4 cm. x 1.0 cm. x 0.10 cm.</p> <p>6. Right hip partial thickness pressure injury a stage 2 measuring 4.2 cm. x 3.5 cm x 0.1 cm.</p> <p>On 9/27/24, V12 identified treatment orders for all wounds listed above to be leptospermum honey with a gauze island bordered dressing to be changed daily and PRN (as needed).</p> <p>On 10/22/24 at 9:23 AM, V3 (Wound Care Nurse) said the former wound care nurse V12 was let go at the facility on 9/25/24 and she was appointed the facility wound care nurse that same day. V3 said she came into the new wounds with R1 and would do her best to answer questions relative to the wounds. V3 said ideally pressure injuries are discovered as a stage 1 and CNA's (Certified Nursing Assistants) should immediately report skin changes to the nurses who should assess the wounds and immediately call for treatment orders. V3 said skin checks should be completed on shower days, when CNA's provide turning and re-positioning and incontinence care to residents. V3 confirmed R1 is a resident who is completely dependent on staff for her cares including re-positioning and incontinence cares. V2 (Director of Nursing) requested to be and was present and collaborated with V3 during the interview about R1's wounds. V2 verified that 6 new wounds were discovered on R1 between 9/24- 9/27 when V7 saw R1.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/22/24 at 12:39 PM, V7 (Wound Care Physician) said pressure injuries found past a stage 2 are a little late to the game being identified, especially wounds with necrotic tissue in the wound beds because these wounds are now advanced and more difficult to heal and don't just happen overnight. V7 said that is on the nurses and CNA's for not identifying these wounds sooner if they are providing care to the patient and doing incontinence cares and turning them regularly they should be noticing the areas sooner, multiple stage 3 pressure injuries being identified and pressure injuries to both sides of the body is concerning. V7 said even though R1 had co-morbidities that would contribute to her developing the wounds since she was on hospice he feels sometimes residents on hospice do not get the same care as non hospice residents because the assumption is they are going to die so additional care and treatment sometimes is not done.</p> <p>On 10/23/24 at 8:44 AM, V6 (CNA) said R1 has been totally dependent on staff for her cares for months. V6 said turning and repositioning and incontinence care should be provided for residents every 1-2 hours and skin should be assessed at that time and any abnormalities including pink or redness should be immediately reported to the nurse.</p> <p>On 10/23/24 at 10:36 AM, V2 said that R1 had tested positive for Covid on 9/16/24 and that staff should have been in the room a lot. V2 also verified that as of 9/13/24 R1 had no active pressure injuries on her body.</p> <p>The facility provided Skin Care Prevention policy revised on 10/16 shows residents will be evaluated daily for changes in their skin condition and dependent residents will be assessed during cares for any changes in skin including redness.</p> <p>2.) R72's care plan shows she has an active stage 4 pressure injury to her left heel, and requires extensive staff assistance with turning and re-positioning.</p> <p>R72's Pressure Risk Assessment History (Braden Scale) shows she scored a 12 which is high risk to develop a pressure injury.</p> <p>A Wound Assessment Details Report completed by V3 (Wound Care Nurse) on 10/16/24 shows she has a healing stage 4 pressure injury and the plan of care is for protective heel boots to be worn.</p> <p>On 10/21/24 at 9:09 AM, V8 and V9 both (CNA's) put R72 to bed. After they were finished with her care they covered her up and left her heels flat against the mattress with no heel protectors on or pillow under her heels offloading them. On 10/21/24 at 11:18 AM, R72 was still in bed with her heels flat against the mattress and not offloaded.</p> <p>On 10/21/24 at 11:14 AM, V3 said for residents at risk for pressure or who have pressure they use offloading of heels with a pillow or heel protectors. On 10/22/24 at 9:50 AM, V3 said she was not aware of R72 not having her heels off loaded but she should have because she does have a current pressure injury.</p> <p>On 10/23/24 at 8:44 AM, V6 (CNA) said R72 has heel protectors that she should have on when she is in bed or up in her wheelchair.</p> <p>The facility provided Skin Care Prevention policy with a revised date of 10/16 shows residents at risk for skin breakdown will have their heels off loaded off the bed surface.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34314</p> <p>Based on observation, interview and record review the facility failed to ensure a resident was transferred safely and failed to ensure resident's medical devices were not plugged into a power strip. This applies to 2 of 18 residents (R22 &amp; R30) reviewed for safety in the sample of 18.</p> <p>The findings include:</p> <p>1. On October 21, 2024 at 12:05 PM, R22 was eating in the dining room. He stated, everything was fine at the facility except what happened over the weekend with the sit to stand (mechanical lift). He lifted his shirt up and there was a large purple bruise to his left chest rib area.</p> <p>R22's new skin condition incident report dated October 20, 2024 shows, Nurse was informed that resident has a large bruise on his left rib side and left chest . Bruise seems to be in shape of the sit to stand sling. Resident stated that during therapy yesterday they had placed resident on sit to stand machine for therapy.</p> <p>R22's progress note dated October 21, 2024 shows, Resident has bruising on left side of body by armpit and upper rib cage. Does make it hard for resident to move around without pain. Resident does not recall anything happening to him for the bruising to be there. NP (Nurse Practitioner) suggests to send resident out for further evaluation</p> <p>R22's emergency department provider notes dated October 21, 2024 shows, [AGE] year old male presenting from nursing home for left rib bruising that was noted at his nursing home. Per staff he did have PT (physical therapy) on Saturday and the bruising was noted Sunday.</p> <p>On October 22, 2024 at 1:37 PM, V2 Director of Nursing (DON) stated, when she spoke with the CNA (Certified Nursing Assistant (V11 CNA)) who worked over the weekend, he stated, he transferred R22 with a sit to stand instead of a full mechanical lift (hoyer lift). V2 DON stated, R22 is not a sit to stand transfer and should have been transferred with the mechanical lift.</p> <p>On October 22, 2024 at 3:36 PM, V11 CNA stated, he was in a hurry to get R22 up for breakfast and transferred him using the sit to stand by him self. He didn't know how to transfer him so he just used the sit to stand. Normally even if you use the sit to stand he should of also had another CNA to help him during the transfer. He denies anything happened with the transfer.</p> <p>R22's resident plan of care dated October 3, 2024 shows, he is a 2 person assist with a mechanical lift (hoyer lift).</p> <p>R22's Minimum Data Set, dated dated dated [DATE] shows, he is mildly impaired.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>35174</p> <p>The facility's safe resident policy (no date) shows, Purpose: The safe resident lifting policy exists to ensure a safe working environment for resident handlers . Process and Procedures: .Caregivers (frontline staff) are NOT permitted to upgrade or downgrade a resident's transferring status prior to transfer assessment being conducted by the charge nurse or restorative nurse.</p> <p>2. On 10/21/24 at 11:10 AM, R30 was in bed watching television. R30 had an orange extension cord plugged into the upper wall outlet. The cord went behind and under R30's bed. Plugged into the extension cord was a non-medical grade power strip. The power strip had R30's bed and pressure relieving air mattress plugged into it. R30 stated she has the air pump mattress due to a pressure wound on her heel.</p> <p>On 10/22/24 at 10:10 AM, R30's room still had the orange extension cord and power strip in the same location as 10/21/24.</p> <p>On 10/22/24 at 11:30 AM, V1 Administrator stated medical devices need to be plugged into a medical grade power strip.</p> <p>The facility did not provide a power strip policy at the time of the survey.</p>		

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40085</b></p> <p>Based on interview and record review the facility failed to notify the dietician in a timely manner of a resident with a significant weight loss of 8 lbs. (pounds) 6.2% in one month. This failure resulted in a delay in dietary interventions being implemented and an additional 3.4 lb. 2.81% weight loss in one week. This applies to 1 of 18 residents (R77) reviewed for weight loss in the sample of 18.</p> <p>The findings include:</p> <p>R77's face sheet shows she was admitted to the facility on [DATE] and has diagnoses including cognitive communication deficit, other disorders of the brain, need for assistance with personal cares, and dysphagia.</p> <p>R77's weight summary sheet shows she weighed 129.2 lbs. on 9/21/24 on 10/14/24 she weighed 121.2 lbs. which is an 8 lbs. 6.2% significant weight loss in 24 days. From 10/14/24 she weighed 121.2 lbs. and on 10/21/24 she weighed 117.8 lbs. which was an additional 3.4 lbs. 2.81% weight loss in 7 days.</p> <p>R77's Dietary Review note completed by V4 (Dietician) on 10/22/24 states, I was notified by DON {V2} on the evening of 10/21/24 that resident {R77} has lost weight as of 10/14. Res. latest weight 117.8# does indicate an 8.6% significant weight x 1 month. Interventions added for R77 include a high calorie drink 120 milliliters (ml.) QID (four times a day), and double portions at lunch and dinner.</p> <p>R77's active Physician Order Summary shows an order for dietary consultation as needed and shows the order for double portions at lunch and dinner and a high calorie drink 120 ml four times a day were added on 10/22/24. R77's nursing progress notes do not show that R77's physician was contacted about her weight loss prior to 10/22/24.</p> <p>On 10/22/24 at 9:40 AM, V2 (Director of Nursing) said she notified V4 last evening of R77's significant weight loss. V2 said she is new to the facility and was not sure of the process for nurses reporting weight loss to the dietician.</p> <p>On 10/22/24 at 10:41 AM, V4 said she was not notified about R77's significant weight loss until the evening of 10/21/24. V4 said she pulls the facility weights at the beginning of each month to review weight loss, and ideally the facility should be notifying her immediately of any significant weight loss in between so she can implement interventions. V4 said if she was notified sooner she would have initiated the same interventions.</p> <p>On 10/23/24 at 8:48 AM, V5 (Licensed Practical Nurse/LPN) said when a resident has weight loss the nurse should notify the unit manager and also the Nurse Practitioner.</p> <p>(continued on next page)</p>		

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F 0692  Level of Harm - Actual harm  Residents Affected - Few	The facility provided Weight Change Investigation policy with a review date of 7/14 shows the purpose of the policy is to investigate significant or insidious weight changes. The weight investigation will be initiated with a significant weight change of 5% or more in one month. Once the weight change is identified the facility will contact the dietician and health care provider for interventions.		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35174</p> <p>Based on observation, interview, and record review the facility failed to ensure the bedside suction was maintained for a resident with a history of pneumonia which applies to 1 of 1 residents reviewed for suctioning in a sample of 18.</p> <p>The findings include:</p> <p>R81's Resident Information sheet printed 10/23/24 showed R81 is a [AGE] year old female admitted to the facility on [DATE] with diagnoses which include: hemiplegia/hemiparesis following a cerebral infarction and dysphagia . R81 was readmitted to the facility on [DATE] with diagnoses which include: pneumonia, sepsis, and acute respiratory failure.</p> <p>On 10/21/24 at 10:00 AM, R81 had a bedside suction set up on the nightstand next to 81's bed. The suction canister was full with a clear liquid which appeared to be water. The suctioning equipment (canister, tubing, yankauer) were not dated. The suction tubing and yankauer were hanging down the side of the nightstand with tip of the yankauer up against the nightstand. R81 has some communication difficulties, but answered questions by making appropriate head movements and hand gestures to answer yes and no questions. R81 shook their head and demonstrated a weak cough. R81 was asked if they had to have the staff used the suction equipment for them. R81 nodded yes.</p> <p>On 10/22/24 at 1:10 PM, R81's bedside suction set up was in the same position with the tubing still hanging down the side of the nightstand. V15 Licensed Practical Nurse (administering bolus tube feeding) stated R81 was sent out to the hospital for pneumonia a while ago. V15 stated she was not sure how long R81 had the bedside suction, but it has been for a while. V15 stated she did not know when this was set up with it not having a date on it. V15 was not sure how often suction equipment needed to be exchanged.</p> <p>On 10/23/24 at 8:35 AM, V14 Assistant Director of Nursing stated suction equipment should be exchanged after a certain amount of use, the canister is full, and/or the yankauer and tubing is clogged. When not in use yankauer should be stored in a holder like the original packaging to attempt to keep the yankauer clean as possible between uses. V14 did not know when the equipment was set up in R81's room.</p> <p>R81's current Care Plan dated 7/17/24 showed no focuses or interventions related to oral suctioning and airway management.</p> <p>R81's Physician Orders printed 10/23/24, showed no orders for PRN (as needed) oral suctioning.</p> <p>On 10/23/24 at 9:50 AM, V2 Director of Nursing stated she reviewed R81's current and discontinued orders. V2 stated she could not find a previous order for PRN oral suctioning. V2 stated oral suctioning needs an order, and the equipment should be maintained in a clean manner.</p> <p>The facility did not provide a oral suctioning or suctioning equipment policy at the time of the survey.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>40085</p> <p>Based on observation, interview and record review the facility failed to ensure the required Personal Protective Equipment (PPE) was worn when providing care to residents on Enhanced Barrier Precautions for 2 of 8 residents (R46, R72) reviewed for infection control in the sample of 18.</p> <p>The findings include:</p> <p>On 10/21/24 at 9:08 AM, on the door to R46 and R72's room there was an enhance barrier sign posted which indicated when staff were providing high-contact resident care for R46 and R72 which includes dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs, handling devices including central lines, urinary catheters, feeding tubes, tracheostomy or wound care, gowns and gloves should be worn.</p> <p>On 10/21/24 at 9:09 AM, V8 (Certified Nursing Assistants/CNA had brought R72 back from the shower. V9 (CNA) entered the room and assisted V8 using a mechanical lift they transferred R72 to bed. V8 and V9 removed the wet hoyer sling that was underneath R72 and rolled her from side to side putting a new incontinent brief on her. R72 had a dressing on her left heel and V8 said she had a pressure ulcer to her heel.</p> <p>On 10/21/24 at 9:23 AM, V8 and V9 checked on R46 (R72's roommate) who indicated she would allow them to change her. R46 was soiled in stool and V8 and V9 provided incontinence care to her and changed her incontinence brief. R46 had a suprapubic catheter, and a healing pressure ulcer to her left buttock.</p> <p>During the cares observed on 10/21/24 for R46 and R72 no gown was applied by V8 or V9.</p> <p>R46's active Physician Order Summary shows she has a suprapubic catheter.</p> <p>R72's 10/16/24, Wound Assessment Details Report shows she has an unstageable pressure injury to her left heel which requires a dressing.</p> <p>On 10/21/24 at 9:44 AM, V8 said she was feeling a little overwhelmed and knows better she should have worn a gown when providing cares to R46 and R72.</p> <p>On 10/22/24 at 9:41 AM, V2 (Director of Nursing) said for residents who are on Enhanced Barrier Precautions the staff should wear a gown and gloves when providing direct patient care.</p> <p>The facility provided Enhance Barrier Precautions (EBP) policy last reviewed 4/24/24 shows that when a resident is placed on Enhanced Barrier Precautions gloves and gowns will be used for cares including dressing, bathing, transferring, providing hygiene, changing linens and briefs, or assisting with residents with devices including central lines, urinary catheter, feeding tubes, or wound care. The policy shows that EBP should be used for residents with urinary catheters and wounds.</p>		