

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145990	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/22/2024
NAME OF PROVIDER OR SUPPLIER Symphony Maple Crest		STREET ADDRESS, CITY, STATE, ZIP CODE 4452 Squaw Prairie Road 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 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35541</p> <p>Based on interview and record review the facility failed to supervise a dementia resident to prevent the resident from wandering into rooms of other residents for 1 of 3 residents (R1) reviewed for dementia care in the sample of 5.</p> <p>The findings include:</p> <p>R1's care plan dated 8/11/23 showed R1 was cognitively impaired due to her diagnosis of dementia. The care plan showed R1 had behaviors of wandering throughout the facility, rummaging through others belongings, confusion, poor judgement, impulsivity, and having delusions. The care plan showed, Monitor resident behaviors . Utilize behavior approaches that attempt to keep resident safe and calm .</p> <p>R1's Elopement assessment dated [DATE] showed R1 was at risk for elopement due to her history of wandering, impaired cognition, and exhibiting behaviors of opening doors or exit seeking. The assessment showed R1 had the ability to propel herself in a wheelchair, around the facility.</p> <p>A Facility Reported Incident form dated 4/11/24 showed a facility resident (R2) threw water on R1 after she repeatedly attempted to enter R2's room. The report showed R1 had tried to enter R2's room multiple times on 4/11/24. The report showed R2 had repeatedly told R1 to not enter his room.</p> <p>R2's electronic medical record showed R2 was discharged from the facility on 4/18/24, to his own apartment. R2's resident assessment dated [DATE] showed R2 was cognitively intact.</p> <p>On 4/22/24 at 8:35 AM, R2 was contacted via phone for an interview. R2 stated, I wasn't trying to hurt (R1) or anyone. I threw the water to stop (R1) from coming into my room. She would try to come into my room all the time. Multiple times a day. Staff wouldn't always stop her or they had no idea she was even in my room. I have no idea why she kept coming in. I know she was confused. The day I threw the water, she had tried to come in twice before. The one time I was just coming out of the shower. I kept telling her to get out of my room and that didn't work. My room was right across from the nurses station so staff knew she kept trying to come in. I got maybe two drops of water on her. I just wanted her to stop opening my door and walking into my room.</p> <p>On 4/22/24 at 8:56 AM, this surveyor attempted to interview R1 about the incident on 4/11/24. R1 was confused to place and time. When R1 was asked about R2 throwing water on her, R1 stated, I don't remember that. Why did he do that?</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 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/22/24 at 9:35 AM, R5 (previous roommate of R2) stated, (R2) was just upset when he threw the water at (R1) because she kept coming into our room. He was trying to stop her. That day she had already tried to come in twice before. He was trying to keep her out of our room. She would try to come in our room all the time. She still tries to come into my room a couple of times a week. Staff are busy. She's hard to keep track of. I tell her to leave and she just looks at me. She won't leave until staff come in and take her out. I think she's confused.</p> <p>On 4/22/24 at 11:00 AM, V4 Certified Nursing Assistant (CNA) stated, (R1) wanders all over the building, all the time. I would say she tries to wander into other resident's rooms multiple times a shift. She is very confused. We try to keep track of her. She is not on frequent checks that I know of. I was just told to watch her because she wanders. That day (4/11/24), (R1) kept trying to go into (R2's) room. I was sitting at the nurse's station. I saw (R1) rolling herself down the hallway. The next thing I know, I hear water hit the floor. I look up. (R1) is in (R2's) room, by the door, and her face is wet. (R2) was yelling, telling us to get her out of his room. (R2) was just trying to stop (R1) from coming more into his room. (R1) had no idea what was going on. I got up and immediately got her out of (R2's) room. V4 stated she was hired by the facility in February 2024 but had not received any dementia training since being hired.</p> <p>On 4/22/24 at 11:23 AM, V3 CNA stated she was hired by the facility on 4/1/24. V3 stated she had not received any dementia training during her employment at the facility. V3 stated, I know (R1) is a wanderer and we are supposed to watch her. She propels herself around the building. When we don't see her, we know we have to walk around the building and find her.</p> <p>On 4/22/24 at 9:43 AM, V7 CNA stated R1 tries to enter other resident rooms a lot. V7 CNA stated, (R1) is really confused. We try to watch her but she propels herself all over the building. It's hard to keep track of her.</p> <p>On 4/22/24 at 10:10 AM, V1 Administrator stated, On 4/11/24, (R2) was very frustrated because (R1) kept trying to come into his room. She had tried to come in one time before that day when (R2) had just gotten out of the shower. (R2) told me he threw the water to get her to stop coming into his room. He said he had previously yelled at her to get out and she didn't leave. (R2) was upset because he felt the staff knew (R1) kept trying to come into his room but staff weren't intervening . If a dementia resident is trying to go into other resident rooms, staff are to be checking on that resident's whereabouts every 15-30 minutes. The goal is to make sure we know where the resident is and redirect the resident to avoid any issues.</p> <p>The facility's Dementia policy dated 4/2024 showed, A resident who displays or is diagnosed with Dementia, receives the appropriate treatment and services to attain and maintain his or her highest practicable physical, mental, and psychosocial well-being . The facility's approach to care for a resident living with dementia follow a systemic care process to ensure that residents' individualized dementia care needs are met. The facility will assess, develop, and implement care plans through an interdisciplinary approach .Develop individualized interventions, related to the resident's symptomology and rate of progression . Modify the environment to accommodate resident care needs .</p> <p>The facility's Wandering policy dated 1/2024 showed, The staff will identify residents who are at risk for harm because of wandering behaviors . Interventions to try to maintain safety will be included in the resident's care plan . Staff will institute a care plan, as indicated for residents who are assessed to have a high risk of elopement/exit seeking/wandering .</p>		

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<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>35541</p> <p>Based on interview and record review the facility failed to ensure newly-hired nursing staff received dementia care training and education prior to caring for facility residents. This failure has the potential to affect all 73 residents in the facility.</p> <p>The findings include:</p> <p>The Facility Data Sheet dated 4/22/24 showed 73 residents resided in the facility.</p> <p>On 4/22/24 at 11:23 AM, V3 CNA stated she had received no dementia training or education during her employment at the facility.</p> <p>On 4/22/24 at 11:00 AM, V4 CNA stated she had received no dementia training or education during her employment at the facility.</p> <p>On 4/22/24 at 11:30 AM, the following employee files were reviewed with V9 Human Resources (HR);</p> <ol style="list-style-type: none"> V4 Certified Nursing Assistant's file (CNA) showed V4 was hired on 2/1/24. The file showed no documentation of V4 receiving dementia education or training from the facility. V4's April 2024 timecard showed V4 worked 4/11-4/14/24 and 4/17-4/19/24, providing cares to residents in the facility. V7 CNA's file showed V7 was hired on 2/12/24. The file showed no documentation of V7 receiving dementia education or training from the facility. V7's April 2024 timecard showed V7 worked 4/11, 4/13,4/14, and 4/16-4/19/24, providing cares to residents in the facility. V8 Licensed Practical Nurse/LPN's file showed V8 was hired on 2/19/24. The file showed no documentation of V8 receiving dementia education or training from the facility. V8's April 2024 timecard showed V8 worked 4/13-4/15/24 and 4/19/24, providing cares to residents in the facility. V3 CNA's file showed V3 was hired 4/1/24. The file showed no documentation of V3 receiving dementia education or training from the facility. V3's April 2024 timecard showed V3 worked 4/11, 4/16, 4/18, 4/20, and 4/21/24, providing cares to residents in the facility. <p>On 4/22/24 at 11:35 AM, V9 HR stated all newly hired staff receive dementia training during their orientation class, prior to providing resident cares. V9 HR stated V3 CNA, V4 CNA, V7 CNA, and V8 LPN had not received any dementia training upon hire to the facility because they haven't gone through orientation yet. We needed to get them on the floor as soon as possible to provide cares.</p> <p>On 4/22/24 at 11:29 AM, V2 Director of Nursing (DON) stated, Staff should have dementia training when hired and then annually. We do have nursing staff working the floor that haven't gone through orientation and haven't had the dementia training. When V2 DON was asked how she could ensure the facility's dementia residents are receiving the cares and monitoring they need if staff have not had the dementia training or education, V2 stated, I have only been in my role (DON) for three weeks. I can't speak to any staff that were hired before me.</p> <p>(continued on next page)</p>		

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<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The facility's General Orientation Checklist and Acknowledgement forms (undated) showed Dementia care and resident Elopement education are provided to new staff during an orientation class. The forms showed new staff receive education on the types of Dementia during orientation. Staff also receive education on how care for and communicate with a dementia resident during orientation.</p>		