STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145990	A. Building B. Wing	06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Symphony Maple Crest	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34314 Based on observation, interview, and record review the facility failed to ensure a resident was free from verbal abuse. This applies to 1 of 8 residents (R1) reviewed for abuse in the sample of 8. The findings include: The facility's reported incidents dated June 2, 2024 shows, resident abuse with R1 and V3 Certified Nursing Assistant (CNA). R1 is a [AGE] year-old male who resides at the facility for long term care services. He is alert and oriented with occasional forgetfulness and confusion. Diagnosis include, but not limited to: Diabetes, atrial fibrillation, dementia with psychotic disturbance, depression, CKD (chronic kidney disease) and congestive heart failure. On 6/2/24 at approx. (approximately) 2:40pm (2:40 PM), a staff member (V4 Registered Nurse (RN) reported to administrator that a CNA (V3) was observed telling R1 to shut up and go to his room. Findings: The facility conducted a thorough investigation pertaining to the allegation of abuse. Based on interviews with R1 and facility staff, including witnesses, the facility does substantiate verbal abuse. On June 17, 2024 at 11:30 AM, R1 was sitting up in his wheelchair in his room. He stated, sometimes the staff is in a mood but no one has been mean to him. He did not remember the incident on June 2, 2024. On June 17, 2024 at 9:59 AM, V4 RN stated, she was giving report to the second shift nurse when they heard some yelling. They paused their report and heard more yelling. They stepped out of the medication room and saw V3 CNA coming away from R1's room (right across from the nursing station) after she slammed his door. V4 RN stated, she told V3 CNA she could not yell at him like that or shut his door. R1 is a fall risk and to open the door back up. V3 CNA stated, well he needs to shut up. V4 RN said that was not right and reported the incident to V1 Administrator right away because you can't treat residents that way. On June 17, 2024 at 12:25 PM, V5 CNA stated, her statement has more details but from what she remembered, she was at the nurses station getting report from another CNA. She wasn't paying full attention but she heard V3 CNA tell R1 he needed to be quiet and pushed him into his room. R1 came back out of his room saying, don't push me and other comments. V3 CNA walked back and pushed him back in the room, told him to be quiet and slammed the door. At that point, the nurses came out and saw what was going on. I think he had gotten on her nerves. She stated, V3 CNA should have handled the situation differently. She also stated, she heard V3 CNA tell the nurse that R1 needed to shut up. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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	145990	A. Building B. Wing	06/17/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	V5's CNA statement dated June 2, 2024 shows, During report V3 CNA heard R1 speaking and she began yelling at him telling him that he was being rude for interrupting because she was getting report. R1 then began talking back to her, then V3 CNA walked out of the nursing station approaching R1 yelling that he needed to be quiet. She grabbed his wheelchair pushing him into his room telling him he needed to stop. V3 CNA came back to the nursing station as R1 continued making comments, before she could sit down she became irritated walked back into residents room pushing him further back after he said, don't you come and push me back and she replied, you can just stop and slammed the door in his face. The PM nurse (V6 RN) then intervened telling V3 CNA it was not okay to yell at the resident. The AM nurse (V4 RN) then walked over and opened his door stating that he was a fall risk and could not be alone, with the door shut, in his room. V3's employee termination form dated June 7, 2024 shows, she was terminated for asubstantiated resident abuse investigation. On June 17, 2024 at 9:05 AM, V1 Administrator stated, she substantiated the verbal abuse with R1. She (V3 CNA) should of handled it differently. R1's care plan dated February 19, 2024 shows, Focus: R1 may be at risk for potential abuse r/t (related to) mental/emotional challenges as evidenced by: dx (diagnosis) of dementia, confusion and forgetfulness. Interventions: Assure resident that they are in a safe and secure environment with caring professionals. If resident is increasingly upset or agitated during care, ensure resident is safe. Politely excuse yourself and then report situation to supervisor and re-approach resident with assistance or alternative staff. The facility's abuse prevention program- policy dated November 22, 2017 shows, Abuse prevention policy: Residents have the right to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This includes but is not limited to corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms . The facility prohibits abuse neglect, misappropriation of property, and exploitation of its residents, including verbal, mental, sexual or physical abuse; corporal punishment; and involuntary seclusion. The facility has a no tolerance philosophy; persons found to have engaged in such conduct will be terminated.