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	09/16/2025

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0686 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to identify two areas of pressure until becoming unstageable. This failure resulted in one of the wounds requiring debridement and becoming a stage 4 pressure ulcer. This applies to one of three residents (R1) reviewed for pressure in the sample of three.The findings include:The facility face sheet shows R1 to have diagnoses to include Type 2 Diabetes Mellitus, peripheral vascular disease, stage three pressure ulcer of left buttock and stage four pressure ulcer of the right buttock. The facility assessment dated [DATE] shows R1 to be cognitively intact and requires moderate assistance with his personal hygiene. The Physician Order Record (MAR) shows an order dated 2/3/2025 for a skin check to be completed two times per week.The wound assessment details report dated 4/19/2025 shows a new area of pressure was identified to R1's left buttock measuring 4 by 2.25 by 0.25 centimeters (CM) and was listed as unstageable and facility acquired. A second wound assessment details report dated 4/19/2025 shows another area of pressure was identified to R1's right buttock measuring 6.5 by 6 by 0.25 CM with soft necrotic (dead tissue) present and was listed as unstageable and facility acquired.The wound evaluation and management summary dated 4/23/2025 completed by the wound care Physician shows R1 to have two new areas of pressure to his left and right buttock. The right buttock wound was debrided by the Physician and a note was added showing [the previously unstageable necrotic wound has revealed the underlying deep tissue at the muscle/fascia level which had been obscured by necrosis prior to this point. This wound has now revealed itself to be a stage four pressure injury.] The wound measures 6.7 by 7.8 by 1.9 CM. The same summary shows the left buttock to have a stage three pressure injury measuring 3.2 by 2.6 by 0.1 CM.On 9/11/2025 at 12:00 PM, V3 Assistant Director of Nursing (ADON) said she was the nurse who was first alerted by staff that R1 had new sores to his buttocks. V3 said R1 always wanted to sit up in his wheelchair and would use the bed pan in his wheelchair to have a bowel movement. R1 would sit on the bed pan for long periods of time and when he was done, he would lift up and the staff would help him to wipe. V3 said the staff would not have been able to see the skin to R1's buttocks this way. V3 said R1 refused showers and would sit up all day and only get into bed late at night. V3 said the new pressure ulcers should have been found before becoming a stage three and a stage four.On 9/11/2025 at 4:00 PM, V2 Director of Nursing (DON) said the purpose of skin checks are to check the skin for redness, ulcers and to check the healing of any skin issues. V2 said the staff providing care for R1 are the ones responsible for doing the skin checks.On 9/11/2025 at 2:30 PM, V4 Wound Care Physician said The reason he has the pressure ulcer is due to the fact he is always up. He refuses to lie in bed. Plus, he has so much pain to his hips and it's worse during transfers, so he is reluctant to move much. Certainly, when he is cleaned up after using the bathroom the staff could have seen changes to his skin. I can't say they should have seen it or how quickly a wound can become necrotic. If you look at my notes, you will see the wound was very advanced when I first saw it. Every time I am there and see him, he is up in his wheelchair.The undated facility policy for skin management program shows it is the facility's policy that a resident does not develop pressure injury unless it is clinically unavoidable. The Certified Nursing Assistants will report any new skin impairments to the licensed nurse identified during daily care.