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	05/26/2026

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 - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview and record review the facility failed to ensure residents were protected from potential abuse when a non-staff individual, who was not screened, trained or authorized by the facility, was permitted to provide resident care including incontinence care, transfers and assisting residents to change clothes for 4 of 4 residents (R4, R5, R6, and R7) reviewed for abuse in the sample of 8.The Immediate Jeopardy began on 5/10/2026 when V5 (Non-Staff Individual) entered the building and began providing resident care.V1 (Administrator) was notified of Immediate Jeopardy on 5/26/2026 at 8:23 AM. This surveyor confirmed by interview and record review that Immediate Jeopardy was removed on 5/26/2026 but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training.The findings include:1. On 5/21/26 at 12:55 PM, R4 said that the other day, V4 (Certified Nursing Assistant- CNA) and another man that she had never seen before (V5-Non-Staff Individual) came into her room. R4 said that V4 said that it was his friend. R4 said that she asked V5 if he was going to start working at that facility and he shook his head yes. R4 said that she thinks that he said his name, but she does not remember. R4 said that V5 stood there and watched V4 get her to bed using the mechanical lift, took off her clothes to put her night gown on and changed her incontinence brief. R4 said that V5 did not do much, he just watched. R4 said, He (V5) saw everything but I figured if he was going to work here, he was going to see it all anyways.On 5/21/26 at 1:10 PM, R8 (R4's roommate) said that V4 and V5 entered her room around 8:00 PM. R8 said that V4 introduced V5 as his friend. R8 said that he was standing at a distance from her but he was about 5'8, black and had dreadlocks. R8 said that he had black clothes on and she did not see a name badge. R8 said that they did not provide any care to her but they did to R4, her roommate. R8 said that it bothered her that V4 had brought a friend in to help him and he saw her roommate exposed. R8 said that she tried to ask V4 about it but he kept avoiding the questions. R8 said that she heard V4 say to V5, We only have 3 left to do. R8 said that it made her feel uneasy so the next day, she informed V1 (Administrator) about the situation.2. On 5/20/26 at 1:10 PM, R5 said that she remembers V4 coming into her room and introducing her to V5 and said that he was going to start working at the facility. R5 said that she does not remember his name. R5 said that she had not seen him in the past and has not seen him since. R5 said that they provided incontinence care to her while she was in bed.3. On 5/21/26 at 9:30 AM, R6 said that he does remember a day when V4 brought in his friend to help him work. R6 said that V5 helped V4 change his brief and reposition him in bed. R6 said that V5 was a black guy that looked like V4. R6 said that he only saw him one time and has not seen him since. 4. On 5/20/26 at 1:14 PM, R7 said that she did have an interaction with V4 and V5. R7 said that V4 entered her room and introduced V5 as his friend. R7 said that V4 and V5 boosted her up in bed but did not provide any incontinence care. R7 said that she told them that they looked like the Boppsey twins because they looked alike. R7 said that they both were African American and they both had dreads. R7 said that she only saw V5 on that day and has not seen him since.On 5/21/26 at 11:39 AM, V4, (CNA) said that on 5/10/26 he had his friend (V5-Non-Staff Individual) come to the facility to meet one of the nurses. V4 said that V5 usually brings him to work and picks him up from work. V4 said that he had V5 enter through the back (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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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	employee entrance. V4 said that he introduced V5 to V6 (Charge Nurse) and then V5 helped him boost a resident up in bed. V4 said that V5 was only in the facility for about 5-10 minutes and he does not recall what time of day it was. V4 said that he has known V5 for about a year but he is unsure if V5 is a CNA or not.On 5/20/26 at 1:49 PM, V8 (CNA) said V4 and V5 came up to her sometime after dinner, maybe around 7:00 PM, and V4 introduced V5 as his boyfriend and said that he was going to be working at the facility. V8 said that she immediately went to V6 (Charge Registered Nurse-RN) and she did not know anything about him working. V8 said that V5 was wearing blue or black scrubs, was African American and had dread locks. V8 said that she had never seen V5 at the facility prior to that day and has not seen him since. On 5/20/26 at 4:10 PM, V6 (Charge RN) said that on 5/10/26, there were three CNAs scheduled to work the PM shift. V6 said that around 6 or 7 PM, V4 came up to her and introduced her to V5. V6 said that V4 introduced him as his boyfriend and said that he was going to work the unit with him. V6 said that she asked V4 if he got that approved first and he said, yes. V6 said that she didn't know that V4 was not telling her the truth so she did not check with V2 (Director of Nursing-DON). V6 said, Looking back, I should have checked with [V2]. V6 said that V5 was a tall, thin, African American with dread locks.On 5/20/25 at 2:07 PM, V7 (Receptionist) said that around 6:00 PM, V4 came up to her at the front desk and said that one of his friends were coming in to help him and it was approved by V2. V7 said that V4 never said who was coming in to help but she figured it was a work friend that he was talking about. V7 said that around 7:40 PM, she looked down the hall way and she saw V4 and V5 going in and out of resident rooms. V7 said that she had never seen V5 at the facility in the past. V7 said that V5 was African American, had dreads and was wearing black scrubs.On 5/20/26 at 2:44 PM, V1 (Administrator) said that on 5/10/26 around 11:00 PM, she heard from V2 (DON) that V4 had had his boyfriend (V5) work with him that night. V1 said that she immediately had staff make sure he was no longer there and then started an investigation that next morning. V1 said that through her investigation, V4 did admit to having a friend that came to the facility but would not provide a name. V1 said that non-staff members should never be allowed in the facility to provide resident care. V1 said that V5 was not and is not an employee of the facility and should have never been at the facility in resident care areas or providing resident care. V1 said that it would be very unsafe for the residents and expose them to potential abuse if an untrained, non-staff member provided care to them. On 5/20/26 at 2:25 PM, V2 (Director of Nursing) said that on 5/10/26, V4 had called her and asked if he could have another CNA that works at the facility come in to help him. V2 said that she informed V4 that if he could get anyone to come in, she would give them a bonus. V2 said that when she said that, she meant anyone who is employed by the facility. V2 said that around 11:00 PM, she received a call from V9 (Night Shift Licensed Practical Nurse) stating she had heard that V4 had brought his boyfriend in to help get residents ready for bed. V2 said that at that time, V4's shift had already ended. V2 said that she immediately notified V1 and they started an investigation on 5/11/26. V2 said that there are many reasons why a staff member should not have random people come help with resident care. V2 said that it is not safe for the residents because the person has not had a background check, they have not gone through appropriate training and orientation and it would be strange for a resident to get care from a random stranger. V2 said that the thought of having a random person come in to provide cares to residents is insane. V2 said, Imagine having a strange male coming in and taking care of you.The facility's Incident Investigation shows that on 5/10/26 at approximately 11:00 PM, DON (Director of Nursing) became aware that an individual who was not employed by the facility was observed assisting the CNA on the 200 hall. It shows that facility CNAs reported that the individual was present on the unit and assumed he was there to help on 200 hall. Facility nurses observed the individual on the unit following the facility CNA and assumed he was called in. The statement received from V4 showed, [V4] reports that his friend came to see him on Sunday at work. He is unsure what time he arrived. He said that his friend is an aide and he did help him boost some residents in bed. He stated that the nurse was busy, so he had his friend help. He denies any malicious intent but stated that the other aides are so far up each (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	other's butts that he didn't ask them for help.The facility's Abuse Prevention Program-Policy shows, Residents have the right to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment.The purpose of this policy and the Abuse Prevention Program is to describe the process for identification, assessment, and protection of residents from abuse, neglect, misappropriation of property and exploitation. This will be accomplished by: conducting pre-employment screening of employees.orienting and training employees on how to deal with stress and difficult situations.establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment.The Immediate Jeopardy that began on 5/10/2026 was removed on 5/26/2026 when the facility took the following actions to remove the immediacy:- The facility's Abuse Prevention Policy was reviewed on 5/26/26 with no updates at this time.- A Facility wide in-servicing on Abuse Prevention Program-Policy was initiated on 5/26/26 for all staff members on duty and will continue until all staff have been educated.- A Facility wide in-servicing on mandatory and immediate notification of unauthorized persons in the building providing resident care was initiated on 5/26/26 for all staff members on duty and will continue until all staff have been educated.- A facility wide in-servicing on verifying staff identity was initiated on 5/26/26 for all staff members on duty and will continue until all staff have been educated.- An emergency QAPI meeting was held with the Medical Director on 5/26/26.- The front and back door codes were changed on 5/26/26 and staff must use assigned badge to enter the facility.- All residents Abuse and Neglect assessments and care plans were reviewed and updated if appropriate on 5/26/26.- Residents and staff will be audited five times weekly, including evening and night shifts and weekends for 4 weeks and audits will be reviewed at QAPI with IDT and Medical Director.