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	06/08/2026

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on interview and record review the facility failed to ensure a resident was provided a shower or bed bath. This applies to 1 of 3 residents (R1) reviewed for showers in the sample of 3. The findings include:On 6/8/26 at 9:22 AM, V3 (R1's Family Member) said he visited R1 on the weekend of 5/23/26 to 5/25/26. V3 said R1's hair was dirty and matted, R1's fingernails were dirty, and R1 appeared unkempt. R1's shower task for the past 30 days shows R1 was not provided a shower, bath, or bed bath from 5/16/26 to 6/1/26. On 6/8/26 at 12:08 PM, V1 (Administrator) said staff should be providing or offering baths or showers at least twice weekly to residents. V1 said staff document that showers or baths are provided or offered under the tasks part of the electronic medical records system. V1 said that is the only place staff document providing showers or baths. The task also shows if the resident refused the bath or shower. Facility Shower; Bathing policy dated 7/2025 states, All residents will be offered a shower and/or a bed bath at least weekly unless a physician order to the contrary is present in the medical record.

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