STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145446	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marigold Rehabilitation Hcc	275 East Carl Sandburg Drive Galesburg, IL 61401

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation, record review and interview the facility failed to post grievance/complaint procedures in a prominent location throughout the facility and promptly address resident grievances. This has the potential to affect all 67 residents residing in the facility. Findings include: The Resident Grievance Process-Senior Living Policy, undated, documents Policy: Utilization of the grievance form offers residents, families, or resident representatives an opportunity to make written accounts of their concerns utilizing the grievance form. Any resident or their representative may complete a grievance concerning his or her treatment, medical care, safety, or other issues without fear of reprisal of any type. The Administrator/Executive director will act as the community designated grievance official. The Administrator, with the assistance of the Social Service Designee, will be responsible for the oversight of the grievance process. Each grievance will be investigated an addressed with a response. The actual response may be completed be a department head and will be reviewed by the Administrator. Procedure: Grievance forms are to be located throughout the community at all nurse's stations and the front desks. The Social Services Designee or the employee responsible for the process will take a copy of all open grievance forms to the daily morning/Quality Assurance meeting for review by the Administrator/Executive Director will ensure grievances are addressed and resolved within a five-day time frame and outcome communicated to the person originating the grievance. Th appropriate department head will investigate grievances, document findings, and then return the grievance form to the Social Services Designee or the employee responsible for the grievance procedure. R21's Grievance, dated 5/8/25, documents, I have had difficulty with getting a full head to toe bath and my hair shampooed. I would like to discuss a shower plan at a care plan meeting with the Ombudsman there to support me. I would also like to discuss call lights not being answered in a timely manner by staff, staff not having access to needed supplies needed on a regular basis. Please let me know a date and time when we can meet and I'll coordinate with the Ombudsman This same grievance does not document steps of investigation, summary/findings, or recommendations/actions taken. On 7/21/2025 at 10:29 AM, R21 was in her room, in her bed, and in a pleasant mood. R21 stated I have had a lot of issues and I have tried to voice them by filing a grievance. (V3/Ombudsman) assisted me in completing one on 5/8/2025. R21 stated that V5 (Activities Director) is in charge of grievances but V5 is not helpful because it is her way or the highway. This is why I asked V3 to help me fill out the grievance on 5/8/25. (continued on next page)

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/21/2025 at 12:16 PM, V3 (Ombudsman) stated R21 asked V3 to assist her in writing a grievance on May 8th, 2025. V3 stated I took a picture of the grievance before I handed the grievance to the (V1 (Administrator) because the facility has stated before they never received the grievances. V3 stated the main request that R21 wanted to accomplish was a care plan meeting where I would attend with her. V3 stated V1 had told her that V21 (MDS) was gone on medical leave, and he would get back to her, and he has yet to get back to her. On 7/21/2025 at 3:06 PM, V5 (Activities Director) stated (V1) had (R21's) 5/8/2025 grievance and just gave it to me last week. I have not started this grievance. On 7/22/2025 at 11:00 AM, V1 stated Once (V3) handed me the grievance, I explained that (V21) was out due to (R21) wanting to have a care plan meeting. I have not documented anywhere that I have addressed (R21's) grievance or spoke to the (V3) regarding setting up a care plan meeting. V1 confirmed this grievance was not investigated and there is no resolution. On 7/22/25 at 10:06 AM during resident council meeting R2, R3, R24, R33, R35, R44, R51, R59, R67 all stated that they do not know where or how to file a grievance. On 7/22/25 at 10:09 AM R21 and R59 stated they (the facility) does not follow up with grievances promptly or at all sometimes. On 7/22/25 at 12:36 PM a tour was conducted with V1/Administrator asking V1 to show where the prominent location(s) are for the grievance procedure in the building. V1 verified there was not a posted grievance procedure in any prominent locations around the building. The facility's CMS (Centers for Medicare and Medicaid Services) Long Term Care Facility Application for Medicare and Medicaid Form 671 dated 7/22/25 and signed by V1/Administrator documents 67 residents currently reside within the facility.

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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 - Immediate jeopardy to resident health or safety Residents Affected - Some	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** Based on observation, interview, and record review the facility failed to protect a resident with severely impaired cognition from resident-to-resident sexual abuse and failed to protect a resident from resident-to-resident physical abuse for four of four residents (R26, R35, R42, R62) reviewed for abuse in the sample of 38. This failure resulted in R35 a cognitively intact resident sexually assaulting R42 a cognitively impaired resident, on more than one occasion. These failures resulted in an Immediate Jeopardy. The Immediate Jeopardy started on 4/7/25 when R35 entered R42's room and sexually assaulted her within the facility. V2 (Director of Nursing) and V26 (Regional Nurse) were notified of the Immediate Jeopardy on 7/24/25 at 4:10 PM. While the immediacy was removed on 7/25/25, the facility remains out of compliance at a severity Level II as additional time is needed to evaluate the implementation and effectiveness of their removal plan and Quality Assurance monitoring. Findings include: The facility's Abuse, Prevention, and Prohibition Policy, undated, documents Statement of Intent: Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. Policy: This facility prohibits mistreatment, neglect, or abuse of resident. This also includes deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, psychosocial well-being. This presumes that all instances of abuse, even those residents in a coma, can cause physical harm, pain, or mental anguish. The facility also prohibits misappropriation of resident property. The residents must not be subjected to abuse by anyone. The facility will educate all employees upon hire including definitions pertaining to abuse and neglect. Annually, the Administrator will contact local law enforcement to review the requirements for reporting to law enforcement. Prevention: The resident has the right to be free from verbal, mental, sexual, exploitation, or physical abuse; corporal punishment and involuntary seclusion. The owner, licensee, Administrator, employee, or agent of the facility shall not abuse or neglect a resident and must prohibit the misappropriation of property. Resident behaviors will be monitored for changes, which trigger abusive behaviors. The facility will reassess care plan interventions on a regular basis. Intervention strategies based on resident screenings will be implemented to prevent occurrences of abuse. Definitions: Abuse: means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, caused harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled using technology. Physical abuse includes, but is not limited to, hitting, slapping, punching, biting, and kicking. Sexual abuse is defined as non-consensual sexual contact of any type with a resident. (continued on next page)

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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 - Immediate jeopardy to resident health or safety Residents Affected - Some	R42's current Care Plan, dated 1/6/25, documents R42 has diagnoses including but not limited to dementia, poor safety awareness, confusion, Bipolar disorder, Schizoaffective, depression and anxiety. This care plan does not address any plans of care regarding R42 being at risk for or a victim of Abuse or interventions to protect R42 from being abused. R42's current Minimum Data Set assessment dated [DATE], documents R42 has severe cognitive impairment. On 7/22/2025 at 10:40 AM, R42 sitting in her room in a wheelchair with a mechanical lift sling under her. R42 stated (when asked if she has had any incidents with other residents coming into her room or touching her) There was something, but I can't remember. R42 was tearful at moments and confused with conversation. On 7/22/2025 at 10:45 AM V9 (Licensed Practical Nurse) confirmed she was working in April when R35 was observed inappropriately touching R42. V9 stated April 2025 would have been the first incident where (R35) was in (R42's) room with his hands on her stomach and breast area with her breasts exposed. There was a second incident, but I do not know what time of day or who was working. I know that the second incident was the same allegation of basically fondling. I heard through chatter of staff that it happened a second time, I believe in May 2025. On 7/22/25 at 11:30 AM, V12 (Certified Nursing Assistant) confirmed she was working and a witness when R35 was found in R42's room. V12 stated I was the one who saw (R35) in (R42's) room back in April (2025) inappropriately touching her. I was walking by and saw (R35) had his hand in (R42's) shirt under her breast area and was rubbing her back and forth. I think we put (R35) on 15-minute checks, I am not sure for how long. V12 confirmed R42 has severely impaired memory and is not able to recall events or provide any history. R35's Minimum Data Set assessment, dated 7/10/25, documents R35 is cognitively intact. R42 and R35's Incident investigation, dated 4/12/25, documents R35 and R42 were involved in a resident-to-resident altercation. The incident final report, dated 4/18/25, documents R35 was rubbing R42's abdomen after being asked by her to do so. This report documents The facility has taken the following actions based on the facts and conclusions of the investigation: (R35) was educated on asking staff for assistance instead of helping residents himself. On 7/23/25 at 9:10 AM, V9 (Licensed Practical Nurse) stated When I was working on 4/7/25, (R35) was observed touching (R42). (R42) had her shirt above the breast. Her breasts and abdomen were exposed. (R35) was groping her inappropriately and she was exposed. The door was open. (R35) didn't care, he was just in there quick and (V12) happened to be walking by and witnessed what was going on. He was groping her inappropriately and she was exposed. It was not just rubbing her belly. On 7/23/25 at 11:00 AM, V15 (Licensed Practical Nurse) stated I just started working in the facility in June or maybe May 2025, but no earlier. I came in one day and asked why (R35) was on 15-minute checks, when I got report. I was told it was because (R35) had his hand in (R42's) brief and pants. (V1, Administrator) and (V2, Director of Nursing) were aware because they are the ones who originally said for staff to do 15-minute checks with (R35). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R42's nursing progress notes, risk management notes, care plan and assessments do not document any incidents of sexual abuse, touching of R42's private areas or interventions to alert staff to the incident occurring between R42 and R35 in April or May 2025. R35"s electronic medical record, dated 3/1/25-7/24/25, does not document that R35 has had sexual abuse allegations and does not document interventions or notes make staff aware of this behavior. On 7/23/25 at 3:00 PM, V1 (Administrator) and V2 (Director of Nursing) confirmed that R35's medical record does not document risk management notes or assessments for R35 to document why he was placed on 15-minute checks starting on 4/7/25. V2 stated the reason they started them is because of the incident with R42. On 7/24/25 at 1:30 PM, V2 confirmed R35 can ambulate around the building and that R35's medical record does not document appropriate measure to alert staff of his need for supervision. 2. R26 and R62's Final Five-Day Reported Incident to Illinois Department of Public Health, dated 6/17/25, documents (R26) was being repositioned, and (R26) reached over and hit (R62) on her shoulder. R26's Face Sheet documents R26 is a [AGE] year-old-female with the following but not limited to diagnosis: Alzheimer's disease with late onset, Dementia with mood disturbance, Bipolar Disorder, Mood disorder due to known physiological condition with depressive features. R26's current Care Plan documents (R26) has a behavior problem: physical aggression towards staff (triggers: overstimulation and increased noise levels and moving too quickly with cares) verbal aggression towards staff/peers (triggers: overstimulation, increased noise levels and moving too quickly with cares) signs and symptoms anxiety-restlessness (triggers: unsure of her surroundings and not being able to fully understand what is going on around her) signs and symptoms depression-crying/tearfulness (triggers: wanting to go home) hallucinations/delusional thinking/psychotic features (triggers: not understanding what is going on around her and overstimulation). R62's Face Sheet documents R62 is a [AGE] year-old-female with the following but not limited to diagnoses: Essential (Primary) Hypertension, Pure Hypercholesterolemia. R62's MDS (Minimum Data Set) Assessment, dated 6/11/25, documents R62 is cognitively intact. R62's Progress Note dated 6/9/2025 at 9:21 PM and signed by V22 (Registered Nurse) documents, The writer was notified by the CNA (identified as V13/Certified Nursing Assistant) that at 1630 the (R62) was hit on her right shoulder by the roommate (identified as R26). On 7/21/2025 at 10:09 AM, R62 stated R26 is known to be verbally and physically aggressive with staff while they are doing cares. R62 stated (R26) was in her bed, the staff turned (R26) towards me while I was sitting in my recliner chair and (R26) hit me in the shoulder. On 7/22/2025 at 9:15 AM, V2 (Director of Nursing) stated (R26) is known to be physically aggressive during cares. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 7/22/2025 at 10 AM, V13 (Certified Nurse Assistant) stated, While I was performing (R26's) incontinence cares, I turned (R26) over in bed during incontinence care and (R26) reached over and hit (R62) on her shoulder when (R62) was sitting in her recliner. (R62) then got up using her wheeled walker and walked out of the room. On 7/30/25 the surveyor confirmed through interview and record review that the facility took the following actions to remove the Immediate Jeopardy: 1. R42 has received skin, pain, and trauma assessments, and their care plan was reviewed and updated as appropriate by social services director (V29), MDS coordinator (V10), and facility nursing staff on 7/25/25 2. 1:1 supervision on R35 has been implemented 7/24/25 to provide safety and adequate supervision for abuse for a period of 72hr and may be extended if results of psychiatric and medication review determine need. Social Services to meet with R35 and R42 for any trauma related concerns. 1:1 continues at this time Monday 7/28/2025 and will be reevaluated on Friday 8/1/2025 3. R35 had psychiatric evaluation and was completed by facility contracted psychiatric provider on 7/25/25. Facility medical director completed medication review on 7/25/25. 4. Administrator (V1), Director of Nursing (V2), Assistant Director of Nursing (ADON, V30), Housekeeping Supervisor (V43) were educated on Abuse and Neglect Policy and Procedure with special focus on sexual abuse identification and reporting by Regional Clinical Nurse (V26) Friday 7/25/2025 5. Agency and routine employees were/will be educated by the Regional Nurse (V26) or designee on the abuse policy and process of reporting abuse allegations with special focus on sexual abuse identification and reporting currently working when issue was reported or before to be completed by 8/1/2025 6. Agency staff and new employees will be educated by ADON (V30) or designee on the abuse policy and process of reporting abuse allegations prior to working the floor. The Director of Nursing (V2) or designee will be responsible for this education before working. Completion date 7/25/25

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on Interview and Record review the facility failed to report an allegation of resident-to-resident sexual abuse to the local police department and report allegations of sexual abuse and physical abuse timely to the State Agency for four of four residents (R26, R35, R42, R62) reviewed for abuse in the sample of 38. Findings include: The facility's Abuse, Prevention, and Prohibition Policy, dated 12/2024, documents Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. Abuse Prohibition Program: The facility Administrator will be designated as the facility Abuse Coordinator and will be responsible for overseeing the Abuse Prevention and Prohibition Program and directing any abuse investigation. If the Administrator is not available to address this role, the Administrator will designate a person in charge in their absence to fulfill the role. This person would normally be the Director of Nursing. Reporting/Response: The facility employee or agent, who becomes aware of abuse or neglect, including injuries of unknown origin or alleged misappropriation of resident property, shall immediately report the matter to the facility Administrator or his/her designated representative in the Administrators absence. An employee or agent or any covered individual will make or cause a report to be made to law enforcement and the facility. The facility Administrator, employee, or agent who is made aware of any allegation of abuse or neglect shall report or caused a report to be made to the mandated state agency per reporting criteria. Such reports may also be made to local law enforcement agency in the same manner. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property will be reported immediately to the Administrator. The person made aware of the allegations of abuse or neglect, or the Administrator will report the allegations of abuse and neglect to the mandated state agency and law enforcement. The allegation will be reported no later than two hours, or per state regulations, after the allegation is made. This policy also documents Physical abuse includes, but is not limited to, hitting, slapping, punching, biting, and kicking. Sexual abuse is defined as non-consensual sexual contact of any type with a resident.1. On 7/23/25 at 9:10 AM, V9 (Licensed Practical Nurse) stated When I was working on 4/7/25, (R35) was observed touching (R42). (R42) had her shirt above the breast. Her breasts and abdomen were exposed. (R35) was groping her inappropriately and she was exposed.R42 and R35's Incident investigation, dated 4/12/25 and completed by V1 (Administrator), documents an initial report of a resident-to-resident altercation was sent to the State Agency on 4/12/25 (five days after the allegation was reported to V1). R42 and R35's final Incident Report, dated 4/18/25, documents a final report was sent to the State Agency on 4/18/25 (11 days after the allegation was reported.) R42 and R35's electronic medical records, risk management notes and incident investigation do not document that local law enforcement was notified of the alleged sexual abuse between R35 and R42 in April 2025.On 7/24/25 at 1:30 PM, V1 (Administrator) confirmed that the initial abuse report for R42 and R35 was sent to the state agency five days after the allegation took place and that local law enforcement was never notified of the sexual abuse allegation.2. The facility's State Preliminary Incident Investigation Report dated 6/10/2025 documents a resident-to-resident altercation between R26 and R62. R62's Progress Note dated 6/9/2025 at 9:21 PM and signed by V22 (Registered Nurse) documents, The writer was notified by (V13/Certified Nurse Assistant) that at 4:30pm (R62) was hit on her right shoulder by (R26). (V13) reported that during cares, she was turning (R26) onto her left when (R26) extended her right hand and hit (R62) who was sitting in the recliner by the bed. (R62's) right shoulder skin check was done and no bruises, skin tear or injury noted. (R62) complained of right shoulder pain which she rated as 3/10. Ice pack was applied. (V1/(Administrator), on-call nurse, and both Power of Attorney's were notified. Physician was notified by fax. Will continue to monitor.On 7/22/2025 at 10 AM, V13 (Certified Nurse Assistant) stated, While I was performing (R26's) incontinence cares, I turned (R26) over in bed during incontinence care and (R26) reached over and hit (R62) on her shoulder when (R62) was sitting in her recliner. (R62) then got up using her wheeled walker and walked out of the room.On 7/22/2025, V1 (Administrator) confirmed he did not report within the 2-hour window. V1 stated, The resident-to-resident altercation between (R26) and (R62) happened on 6/9/25 not 6/10/25. I didn't report the incident to the state agency until 6/10/25. I wasn't aware I had to report it within two hours.