

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145446	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/25/2025
NAME OF PROVIDER OR SUPPLIER  Marigold Rehabilitation Hcc		STREET ADDRESS, CITY, STATE, ZIP CODE  275 East Carl Sandburg Drive Galesburg, IL 61401	

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.  (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on record review and interview, the facility failed to ensure a resident remained free from physical abuse. This failure affects one of three residents (R1) reviewed for abuse in a total sample of three residents. This failure resulted in R1 being pushed by R2, causing R1 to fall to the floor after losing R1's balance. Findings include: The facility policy, entitled Abuse, Prevention, &amp; Prohibition Policy, dated 12/2024, documents: 3. Resident to Resident abuse includes the term willful. The word willful means that the individual's action was deliberate (not inadvertent or accidental), regardless of whether the individual intended to inflict injury or harm. 4. An example of a deliberate (willful) action would be a cognitively impaired resident who strikes out at a resident within his/her reach, as opposed to a resident with a neurological disease who has involuntary movements (e.g., muscle spasms, twitching, jerking, writhing movements) and his/her body movements impact a resident who is nearby. R1's Electronic Medical Record/EMR document R1's diagnosis to include: Dementia with psychotic disturbance, chronic obstructive pulmonary disease, type two diabetes mellitus, hyperlipidemia, hypertension, major depressive disorder, vitamin B deficiency, peripheral vascular disease, and primary osteoarthritis.R1 resides on a locked dementia unit and R1 is not cognitively intact-with a Brief Interview for Mental Status of 1/15. R1 ambulates without assistance.R1's EMR documentation, entitled Risk Management document, Date of Incident 8/10/25 6:45 p.m., V6 [Certified Nursing Assistant] came over to get nurse and expressed that an incident between two residents had just occurred. V6 stated that [R2] shoved [R1] and caused [R1] to lose balance and fall on the floor onto buttock. V6 and V7 [CNA] expressed that [R1] kept bothering [R2] and had to be removed twice from getting too close into [R2's] space.R2's EMR document R2's diagnosis to include: Dementia with Anxiety, Chronic Obstructive Pulmonary Disease, Urinary Tract Infection, Hypertension, Iron Deficiency, Gastroesophageal Reflux Disease, Anxiety, Major Depressive Disorder, Hyperlipidemia, Depression, Obesity, Diverticulitis, Gout, Congestive Heart Failure, Benign Prostatic Hyperplasia, Congenital Hiatus Hernia, and Spinal Stenosis.R2 resides on a locked dementia unit and R2 is not cognitively intact-with a Brief Interview for Mental Status as 0/15. R2 ambulates in a wheelchair.R2's EMR documentation, entitled Risk Management documents, Date of Incident 8/10/25 6:45 p.m., V6 came over to get nurse and expressed that an incident between two residents had just occurred. V6 CNA stated that [R2] shoved [R1] and caused [R1] to lose balance and fall on the floor onto buttock. Both V6 and V7 expressed that the [R1] kept bothering [R2] and had to be removed twice from getting too close into [R2's] space. On 9/25/25, at 10:00 a.m., V6/Certified Nursing Assistant-CNA confirmed: observing the incident with R1 and R2; R1 initially walked up the R2 in the hallway and entered R2's personal space; R1 was redirected; R1 then approached R2 a second time in the day room; R2 then pushed R1 and R1 lost her balance and fell; the V11 Licensed Practical Nurse was down the hall, on the dementia unit, when the incident occurred; and R2 does not even like staff to enter R2's personal space when talking to R2. On 9/25/25, at 11:05 a.m., V9/CNA confirmed R1 will often enter the personal space of other residents and R1 would then have to be redirected; and R2 only gets aggressive during ADL's/Activities of Daily Living or with someone he doesn't know.</p>		