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	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marigold Rehabilitation and Health Care Center	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 - Immediate jeopardy to resident health or safety Residents Affected - Few	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 ensure a resident was free from neglect, as evidenced by the failure to provide goods and services necessary to avoid physical harm for one of three residents (R1), reviewed for medications, in a sample of three. The facility failed to administer prescribed medications to R1 in accordance with physician orders. R1's medical record revealed that multiple medications were not administered as prescribed, no timely notification to the physician and no implementation of appropriate interventions. As a result of the facility's failure to provide necessary care and services, R1 experienced a decline in condition and subsequently expired. The failure to administer prescribed medications and to respond appropriately constituted neglect and resulted in actual harm and death to the resident. These failures resulted in an Immediate Jeopardy. The Immediate Jeopardy started on [DATE] when R1 was admitted to the facility from a local hospital, after a prolonged hospitalization for respiratory and cardiac failure, with physician ordered medications and treatments to begin at 4:00 P.M.V1 (Administrator) and V2 (Interim Director of Nurses) were notified of the Immediate Jeopardy on [DATE] at 9:50 A.M.While the immediacy was removed on [DATE], 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 policy, Abuse Prevention and Prohibition policy dated [DATE] documents, This facility prohibits mistreatment, neglect, or abuse of residents. This 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.The (undated) facility Medication Availability policy, directs staff to, On admission, using Quick (computerized program), admit the resident to the facility. Enter allergies. enter physician orders within one hour of the resident entering the facility. make sure the correct date and time are entered. If after 4:00 pm, call the pharmacy notifying them of a new admission- ask to speak to a pharmacist. Review with the pharmacist which medications you will need until the next scheduled delivery. Administer meds (medications) from the EDK (emergency drug kit or convivence kit). For meds not in the EDK, request pharmacy send STAT (immediately) or use their back up pharmacy to get them to the facility. Document administration of the medication in EMAR (Electronic Medication Administration Record).The (facility pharmacy) posted Hours of Operation and Cutoff Times form, located at the facility East Wing nurse's station directs staff, Order Cutoff Times: Monday - Friday New Orders by 4:00 PM and Saturday New Orders by 1:00 PM. STAT SAFE: The stat safe is an automated dispensing cabinet that will allow nurses access to doses of specific medication. Inventory can be customized.The (facility) STAT Safe Inventory List, dated (last update) [DATE] includes some of the following medications, Albuterol (Bronchodilator) Nebulizer Solution, Fluoxetine (Anti-depressant) 20 MG (Milligram) tablet, Prednisone (Corticosteroid) 10 MG tablet, Simvastatin (Statin) 10 MG tablet, Spironolactone (Diuretic) 25 MG tablet, (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Torsemide (Diuretic) 20 MG tablet, Ipratropium (Bronchodilator) Nebulizer Solution.R1's facility admission Record documents that R1 was admitted to the facility on [DATE] from a local hospital with the following diagnoses: Acute on Chronic Respiratory Failure with Hypercapnia, Acute Respiratory distress, Chronic Obstructive Pulmonary Disease, Pulmonary Hypertension, Acute on Chronic Diastolic (Congestive) Heart Failure, Chronic Cor Pulmonal.R1's (Hospital) After Visit Summary documents that R1 was hospitalized from [DATE] until [DATE] and includes the following physician orders: Oxygen at 5 liters per nasal cannula continuously. Upon admission, R1 had new physician orders to start the following medications: Acetazolamide (Carbonic anhydrase inhibitor used for edema in heart failure); Clonazepam (Benzodiazepine); Ipratropium-Albuterol (Bronchodilator); Prednisone (Corticosteroid) start [DATE], Fluticasone (Corticosteroid) start [DATE]. R1 also had a physician's order to continue the following medications: Albuterol (Bronchodilator); Cyanocobalamin (Supplement); Folic Acid (Supplement) and MiraLAX (Laxative). R1 also had a physician's order to continue taking Aspirin; Budeson- Glycopyrrolate-Formoterol (Bronchodilator); Fluoxetine (Antidepressant); Guaifenesin (Mucolytic); Pantoprazole (Proton Pump Inhibitor); and Simvastatin (Statin). R1's Daily Skilled Nursing Note on [DATE] at 2:30 P.M. document, (R1) is alert and has short term memory problem. (R1) does not have delusions, does not hallucinate, and decision making is not impaired. Signs of delirium: none. (R1) has the following sensory or speech issues: wears glasses. (R1) has the following indicators of a mood issue: none. (R1) has the following behavioral issues: none. (R1) has the following skin issues: Scattered bruising to abdomen and extremities. (R1) is incontinent of bladder. Bowel sounds are normal, has normal bowel movements, is incontinent of bowel. Apical pulse is regular, radial pulse is regular. (R1) is experiencing the following cardiovascular issues: none. (R1) has no edema. Respiratory Status- (R1) is experiencing the following breathing issues: SOB (Short of Breath) at times. (R1) Has SOB while lying flat, has shortness of breath on exertion, does not have shortness of breath or trouble breathing when sitting at rest. Lung sounds: Clear. (R1) does not have a cough and requires the following respiratory support Bi-pap and neb (nebulizer) treatments with O2 (oxygen).R1's Nursing Progress Notes, dated [DATE] at 12:32 P.M., and signed by V5/Licensed Practical Nurse document, Nurse went into (R1's) room to administer medications at 11:39 A.M. (R1) appeared that breathing had ceased. No audible heart tones; no pulse and no visual signs of life noted. DON (V2/Interim Director of Nurse) verified (R1) had expired. Staff had last talked to (R1) approximately 15 minutes prior. (R1) had several complex medical diagnoses, including respiratory failure. R1's October Physician Order Sheet includes the following medications: Enteric Coated Aspirin 81 MG daily at 8AM, Cyanocobalamin 500 MCG (Micrograms) daily at 8AM, Docusate Sodium 100 MG daily at 8AM, Ferrous Sulfate 325 MG daily at 8AM, Fluoxetine 20 MG daily at 8AM, Fluticasone Nasal Suspension daily at 8AM, Folic Acid 1 MG daily at 8AM, Prednisone 5 MG daily at 8AM, Protonix 40 MG daily at 5AM, Simvastatin 40 MG daily at 8PM, Spironolactone 25 MG daily at 8AM, Vitamin D3 1000 Units daily at 8AM, Acetazolamide 250 MG twice daily at 8AM and 4PM, AR formoterol Inhalation Nebulization Solution twice daily at 8AM and 4PM, Breztri Aerosphere Inhalation twice daily at 8AM and 4PM, Clonazepam 0.5 MG twice daily at 8AM and 4PM, Guaifenesin ER (Extended Release) 600 MG twice daily at 8AM and 8PM, Hydroxychloroquine 200 MG twice daily at 8AM and 4 PM, Torsemide 40 MG twice daily at 8AM and 4PM, Ipratropium-Albuterol Inhalation Solution via Nebulization four times daily at 8AM, 12PM, 4PM and 8PM.R1's [DATE] Medication Administration Record documents that R1 did not receive Aspirin, Cyanocobalamin, Docusate Sodium, Ferrous Sulfate, Fluoxetine, Fluticasone, Folic Acid, Prednisone, Spironolactone (Diuretic), Vitamin D3 (Supplement), Acetazolamide, Budeson- Glycopyrrolate- Formoterol, Clonazepam, Hydroxychloroquine (Anti-rheumatic), Torsemide (Diuretic), or Ipratropium-Albuterol on [DATE] or [DATE] at 8AM, 12PM or 4PM., (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	as documented by V5/Licensed Practical Nurse as unavailable. No documentation that the missed medication doses was escalated to facility nurse management staff or that R1's physician was notified that R1 had missed physician ordered medications on [DATE] and [DATE] is present in R1's medical record.On [DATE] at 11:33 A.M., a locked, electronic medication dispensing machine was located in the East Wing Medication Room. A list of medications available in the machine was present, and included Albuterol (Bronchodilator) Nebulizer Solution, Fluoxetine (Anti-depressant) 20 MG (Milligram) tablet, Prednisone (Corticosteroid) 10 MG tablet, Simvastatin (Statin) 10 MG tablet, Spironolactone (Diuretic) 25 MG tablet, Torsemide (Diuretic) 20 MG tablet, Ipratropium (Bronchodilator) Nebulizer Solution. On [DATE] at 1:04 P.M., V5/Licensed Practical Nurse stated she has been an employee of the facility for the past 8 years as a Licensed Practical Nurse. States when a new admission comes to the facility, V8/Minimum Data Set Assessment Coordinator or V9/Assistant Director of Nurses put the orders into the computer. States pharmacy delivery of medications is made between 8 PM to 10 PM each day, except Saturday or Sunday when delivery is usually late afternoon. States if a resident is admitted prior to that, their medications should be delivered that evening. States the facility also has a locked medication cart that contains many different medications. If a resident runs out of medicine or is a new admission and their medications aren't in the facility yet, a nurse can call the pharmacy, and they will give you a code to unlock the machine to pull the medications needed. States she worked on [DATE] and 23, 2025 and that R1's medications had not arrived from the pharmacy. States R1 did not receive medications on those dates. Unable to recall if medications had been placed on hold. States on [DATE] around 11:30 A.M. the CNAs (Certified Nursing Assistants) had gone into R1's room to deliver his noon meal tray and found him deceased . States they came and got her and she assessed R1 and found him without a pulse or respirations. On [DATE] at 1:26 P.M., V10/Medical Doctor stated he was R1's primary physician. States R1's medications, including multiple diuretics, nebulizer treatments and steroids should never have been placed on hold. States R1 should have received his medications, as ordered by the physician. Unable to state if R1 not receiving his medications led to his death on [DATE], but stated it is a very good possibility. Stated it definitely hurt R1's medical condition. Stated his expectation of the facility is that a resident's medications are available on the evening of admission, or he should be notified to modify the treatment plan for a resident. Further stated he was not notified by nursing staff on [DATE], [DATE] or [DATE] that R1's medications were not available. On [DATE] at 2:42 P.M., V7/Advanced Practice Nurse stated she doesn't specifically recall giving an order to hold R1's medications until available. Stated her expectation is that medications should be available upon admission, or the facility should have a means to obtain medications swiftly via a local pharmacy or an in-house electronic dispensing machine. V7 stated she would not expect medications to be unavailable for 48 hours and she or V10/Medical Doctor should have been made aware of the extended time delay in obtaining R1's medications. Stated she was not notified by the facility that R1 did not receive his ordered medications on [DATE], [DATE] or [DATE]. Stated if she had been notified, a new treatment plan could have been implemented for R1 or R1 would have been sent back to the hospital to receive treatment. On [DATE] at 9:08 A.M., V13/Critical Care Pharmacist stated the delivery slip for the facility documents that the following medications were delivered for R1 on [DATE] at 11:18 PM, Arformoterol Inhalation, Acetazolamide, Enoxaparin and Budesonide. V13 stated the Enoxaparin and Budesonide were discontinued on [DATE]. Stated on [DATE] at 12:21 AM, the following medications for R1 were delivered: Torsemide, Spironolactone, Simvastatin, Prednisone, Pantoprazole, Ipratropium-Albuterol Inhalation, Hydroxychloroquine, Fluticasone, Fluoxetine, Breztri and Albuterol. On [DATE] at 11:03 A.M., V2/Interim Director of Nurses stated she was not informed by any (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	nurse that R1's medications were not available or given to him as ordered by the physician. At that time, V2 verified that R1 did not receive physician ordered medications on [DATE], [DATE] or [DATE] including Aspirin on [DATE] and [DATE]; Cyanocobalamin on [DATE] and [DATE]; Docusate Sodium on [DATE] and [DATE]; Ferrous Sulfate, Fluoxetine, Fluticasone, Folic Acid, Prednisone, Spironolactone (Diuretic), Vitamin D3 (Supplement), Acetazolamide, Budeson- Glycopyrrolate- Formoterol, Clonazepam, Hydroxychloroquine (Anti-rheumatic), Torsemide (Diuretic), or Ipratropium-Albuterol on [DATE] or [DATE].On [DATE] at 11:17 A.M., V5/Licensed Practical Nurse stated she did not get medications for R1 from the facility electronic medication dispensing machine on [DATE] or [DATE]. Stated she did not notify R1's physician that he had not received any medications including his breathing treatments, diuretics, medication for heart failure or his prednisone. Stated she doesn't know why she did not administer R1's Diamox or Breztri Inhaler on [DATE] or at 8:00 AM on [DATE] despite them being delivered by the pharmacy on [DATE]. Stated she was busy and was going into R1's room at 11:39 AM when R1 was found deceased . Also stated she did not notify nursing management of R1's missing medications on [DATE], [DATE] or at 8:00 AM on [DATE]. R1's (State) Certificate of Death documents R1's Cause of Death as Acute on Chronic Congestive Heart Failure, Acute on Chronic Diastolic Heart Failure with Significant Conditions Contributing to Death as Chronic Obstructive Pulmonary Disease.On [DATE] the surveyor confirmed through interview and record review that the facility took the following actions to remove the Immediate Jeopardy:On [DATE] Director of Nursing has reviewed all residents that are receiving prescribed medications as ordered.On [DATE] Director of Nursing has reviewed all residents, and no residents have been identified to having missed any doses of prescribed medications.On [DATE] All licensed nurses have been educated by the Director of Nursing and provided access on how to obtain unavailable medications from the facilities emergency medication kit (stat safe) On [DATE] Regional Nurse Consultant educated Director of Nursing on medication administration/availability. And as part of QA activities weekly match back audits are completed for med availability. All new admits should be reviewed to ensure their medications are available and orders in place using the checklist. Which is reviewed daily during clinical QA meeting. Licensed Nursing Staff including V5 were educated by Director of Nursing on [DATE] or prior to working their next scheduled shift on the following:Adherence to physician orders Residents should be assessed timely and documentation completed, and the Physician should be notified in the event an ordered medication dose is missed.Facility Nursing Administration notified immediately of any medication administration issue.Facility Abuse and Neglect Policy related to administering prescribed medications to avoid physical harm to residentsAn audit has been created on [DATE] by the Director of Nursing to ensure compliance with medication administration and availability, assessment and documentation, physician notification and escalation to nursing administration and staff knowledge of facility medication administration standards to avoid physical harm to residents.Director of Nursing or designee will conduct an audit of 3 licensed nurses 3 times per week for 8 weeks to ensure compliance with medication administration standards.Administrator or designee will conduct an audit of 3 licensed nurses 3 times per week for 8 weeks to ensure compliance with medication administration standards to avoid physical harm to residents. Completion date [DATE]

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that a resident received prescribed medications in accordance with physician orders, resulting in a failure to provide necessary care and services to attain or maintain the resident's highest practicable physical well-being, for 1 of 3 residents (R1) reviewed for medications, in a sample of 3. The facility failed to administer prescribed medications to R1 as ordered over multiple days. R1's medical record review revealed that the medications were ordered to be administered routinely; however, documentation showed missed doses without evidence of physician notification, or appropriate intervention. Staff interviews confirmed that missed medications were not escalated to nursing leadership or the attending physician. As a result of the failure to administer prescribed medications and the lack of timely assessment and intervention, R1 experienced a decline in condition and subsequently expired. The facility's failure to follow physician orders and provide appropriate monitoring and response placed R1 at risk for serious harm and resulted in actual harm and death.These failures resulted in an Immediate Jeopardy. The Immediate Jeopardy started on [DATE] when R1 was admitted to the facility from a local hospital, after a prolonged hospitalization for respiratory and cardiac failure, with physician ordered medications and treatments to begin at 4:00 P.M.V1 (Administrator) and V2 (Interim Director of Nurses) were notified of the Immediate Jeopardy on [DATE] at 9:50 A.M.While the immediacy was removed on [DATE], 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 (undated) facility Medication Availability policy, directs staff to, On admission, using Quick (computerized program), admit the resident to the facility. Enter allergies. enter physician orders within one hour of the resident entering the facility. make sure the correct date and time are entered. If after 4:00 pm, call the pharmacy notifying them of a new admission- ask to speak to a pharmacist. Review with the pharmacist which medications you will need until the next scheduled delivery. Administer meds (medications) from the EDK (emergency drug kit or convivence kit). For meds not in the EDK, request pharmacy send STAT (immediately) or use their back up pharmacy to get them to the facility. Document administration of the medication in EMAR (Electronic Medication Administration Record).The (facility pharmacy) posted Hours of Operation and Cutoff Times form, located at the facility East Wing nurse's station directs staff, Order Cutoff Times: Monday - Friday New Orders by 4:00 PM and Saturday New Orders by 1:00 PM. STAT SAFE: The stat safe is an automated dispensing cabinet that will allow nurses access to doses of specific medication. Inventory can be customized.The (facility) STAT Safe Inventory List, dated (last update) [DATE] includes some of the following medications, Albuterol (Bronchodilator) Nebulizer Solution, Fluoxetine (Anti-depressant) 20 MG (Milligram) tablet, Prednisone (Corticosteroid) 10 MG tablet, Simvastatin (Statin) 10 MG tablet, Spironolactone (Diuretic) 25 MG tablet, Torsemide (Diuretic) 20 MG tablet, Ipratropium (Bronchodilator) Nebulizer Solution.R1's facility admission Record documents that R1 was admitted to the facility on [DATE] from a local hospital with the following diagnoses: Acute on Chronic Respiratory Failure with Hypercapnia, Acute Respiratory distress, Chronic Obstructive Pulmonary Disease, Pulmonary Hypertension, Acute on Chronic Diastolic (Congestive) Heart Failure, Chronic Cor Pulmonal.R1's (Hospital) After Visit Summary documents that R1 was hospitalized from [DATE] until [DATE] and includes the following physician orders: Oxygen at 5 liters per nasal cannula continuously. Upon admission, R1 had new physician orders to start the following medications: Acetazolamide (Carbonic anhydrase inhibitor used for edema in heart failure); Clonazepam (Benzodiazepine); Ipratropium-Albuterol (Bronchodilator); Prednisone (Corticosteroid) start (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE], Fluticasone (Corticosteroid) start [DATE]. R1 also had a physician's order to continue the following medications: Albuterol (Bronchodilator); Cyanocobalamin (Supplement); Folic Acid (Supplement) and MiraLAX (Laxative). R1 also had a physician's order to continue taking Aspirin; Budeson- Glycopyrrolate-Formoterol (Bronchodilator); Fluoxetine (Antidepressant); Guaifenesin (Mucolytic); Pantoprazole (Proton Pump Inhibitor); and Simvastatin (Statin). R1's Daily Skilled Nursing Note on [DATE] at 2:30 P.M. document, (R1) is alert and has short term memory problem. (R1) does not have delusions, does not hallucinate, and decision making is not impaired. Signs of delirium: none. (R1) has the following sensory or speech issues: wears glasses. (R1) has the following indicators of a mood issue: none. (R1) has the following behavioral issues: none. (R1) has the following skin issues: Scattered bruising to abdomen and extremities. (R1) is incontinent of bladder. Bowel sounds are normal, has normal bowel movements, is incontinent of bowel. Apical pulse is regular, radial pulse is regular. (R1) is experiencing the following cardiovascular issues: none. (R1) has no edema. Respiratory Status- (R1) is experiencing the following breathing issues: SOB (Short of Breath) at times. (R1) Has SOB while lying flat, has shortness of breath on exertion, does not have shortness of breath or trouble breathing when sitting at rest. Lung sounds: Clear. (R1) does not have a cough and requires the following respiratory support Bi-pap and neb (nebulizer) treatments with O2 (oxygen).R1's Nursing Progress Notes, dated [DATE] at 12:32 P.M. and signed by V5/Licensed Practical Nurse document, Nurse went into (R1's) room to administer medications at 1139 A.M. (R1) appeared that breathing had ceased. No audible heart tones; no pulse and no visual signs of life noted. DON (V2/Interim Director of Nurse) verified (R1) had expired. Staff had last talked to (R1) approximately 15 minutes prior. (R1) had several complex medical diagnoses, including respiratory failure. R1's October Physician Order Sheet includes the following medications: Enteric Coated Aspirin 81 MG daily at 8AM, Cyanocobalamin 500 MCG (Micrograms) daily at 8AM, Docusate Sodium 100 MG daily at 8AM, Ferrous Sulfate 325 MG daily at 8AM, Fluoxetine 20 MG daily at 8AM, Fluticasone Nasal Suspension daily at 8AM, Folic Acid 1 MG daily at 8AM, Prednisone 5 MG daily at 8AM, Protonix 40 MG daily at 5AM, Simvastatin 40 MG daily at 8PM, Spironolactone 25 MG daily at 8AM, Vitamin D3 1000 Units daily at 8AM, Acetazolamide 250 MG twice daily at 8AM and 4PM, AR formoterol Inhalation Nebulization Solution twice daily at 8AM and 4PM, Breztri Aerosphere Inhalation twice daily at 8AM and 4PM, Clonazepam 0.5 MG twice daily at 8AM and 4PM, Guaifenesin ER (Extended Release) 600 MG twice daily at 8AM and 8PM, Hydroxychloroquine 200 MG twice daily at 8AM and 4 PM, Torsemide 40 MG twice daily at 8AM and 4PM, Ipratropium-Albuterol Inhalation Solution via Nebulization four times daily at 8AM, 12PM, 4PM and 8PM.R1's [DATE] Medication Administration Record documents that R1 did not receive Aspirin, Cyanocobalamin, Docusate Sodium, Ferrous Sulfate, Fluoxetine, Fluticasone, Folic Acid, Prednisone, Spironolactone (Diuretic), Vitamin D3 (Supplement), Acetazolamide, Budeson- Glycopyrrolate- Formoterol, Clonazepam, Hydroxychloroquine (Anti-rheumatic), Torsemide (Diuretic), or Ipratropium-Albuterol on [DATE] or [DATE] at 8AM, 12PM or 4PM., as documented by V5/Licensed Practical Nurse as unavailable. No documentation that the missed medication doses was escalated to facility nurse management staff or that R1's physician was notified that R1 had missed physician ordered medications on [DATE] and [DATE] is present in R1's medical record.On [DATE] at 11:33 A.M., a locked, electronic medication dispensing machine was located in the East Wing Medication Room. A list of medications available in the machine was present, and included Albuterol (Bronchodilator) Nebulizer Solution, Fluoxetine (Anti-depressant) 20 MG (Milligram) tablet, Prednisone (Corticosteroid) 10 MG tablet, Simvastatin (Statin) 10 MG tablet, Spironolactone (Diuretic) 25 MG tablet, Torsemide (Diuretic) 20 MG tablet, Ipratropium (Bronchodilator) Nebulizer Solution. On [DATE] at 1:04 P.M., V5/Licensed Practical Nurse stated she has been an employee of the facility (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	for the past 8 years as a Licensed Practical Nurse. States when a new admission comes to the facility, V8/Minimum Data Set Assessment Coordinator or V9/Assistant Director of Nurses put the orders into the computer. States pharmacy delivery of medications is made between 8 PM to 10 PM each day, except Saturday or Sunday when delivery is usually late afternoon. States if a resident is admitted prior to that, their medications should be delivered that evening. States the facility also has a locked medication cart that contains many different medications. If a resident runs out of medicine or is a new admission and their medications aren't in the facility yet, a nurse can call the pharmacy, and they will give you a code to unlock the machine to pull the medications needed. States she worked on [DATE] and 23, 2025 and that R1's medications had not arrived from the pharmacy. States R1 did not receive medications on those dates. Unable to recall if medications had been placed on hold. States on [DATE] around 11:30 A.M. the CNAs (Certified Nursing Assistants) had gone into R1's room to deliver his noon meal tray and found him deceased . States they came and got her and she assessed R1 and found him without a pulse or respirations. On [DATE] at 1:26 P.M., V10/Medical Doctor stated he was R1's primary physician. States R1's medications, including multiple diuretics, nebulizer treatments and steroids should never have been placed on hold. States R1 should have received his medications, as ordered by the physician. Unable to state if R1 not receiving his medications led to his death on [DATE], but stated it is a very good possibility. Stated it definitely hurt R1's medical condition. Stated his expectation of the facility is that a resident's medications are available on the evening of admission, or he should be notified to modify the treatment plan for a resident. Further stated he was not notified by nursing staff on [DATE], [DATE] or [DATE] that R1's medications were not available. On [DATE] at 2:42 P.M., V7/Advanced Practice Nurse stated she doesn't specifically recall giving an order to hold R1's medications until available. Stated her expectation is that medications should be available upon admission, or the facility should have a means to obtain medications swiftly via a local pharmacy or an in-house electronic dispensing machine. V7 stated she would not expect medications to be unavailable for 48 hours and she or V10/Medical Doctor should have been made aware of the extended time delay in obtaining R1's medications. Stated she was not notified by the facility that R1 did not receive his ordered medications on [DATE], [DATE] or [DATE]. Stated if she had been notified, a new treatment plan could have been implemented for R1 or R1 would have been sent back to the hospital to receive treatment. On [DATE] at 9:08 A.M., V13/Critical Care Pharmacist stated the delivery slip for the facility documents that the following medications were delivered for R1 on [DATE] at 11:18 PM, Arformoterol Inhalation, Acetazolamide, Enoxaparin and Budesonide. V13 stated the Enoxaparin and Budesonide were discontinued on [DATE]. Stated on [DATE] at 12:21 AM, the following medications for R1 were delivered: Torsemide, Spironolactone, Simvastatin, Prednisone, Pantoprazole, Ipratropium-Albuterol Inhalation, Hydroxychloroquine, Fluticasone, Fluoxetine, Breztri and Albuterol. On [DATE] at 11:03 A.M., V2/Interim Director of Nurses stated she was not informed by any nurse that R1's medications were not available or given to him as ordered by the physician. At that time, V2 verified that R1 did not receive physician ordered medications on [DATE], [DATE] or [DATE] including Aspirin on [DATE] and [DATE]; Cyanocobalamin on [DATE] and [DATE]; Docusate Sodium on [DATE] and [DATE]; Ferrous Sulfate, Fluoxetine, Fluticasone, Folic Acid, Prednisone, Spironolactone (Diuretic), Vitamin D3 (Supplement), Acetazolamide, Budeson-Glycopyrrolate- Formoterol, Clonazepam, Hydroxychloroquine (Anti-rheumatic), Torsemide (Diuretic), or Ipratropium-Albuterol on [DATE] or [DATE].On [DATE] at 11:17 A.M., V5/Licensed Practical Nurse stated she did not get medications for R1 from the facility electronic medication dispensing machine on [DATE] or [DATE]. Stated she did not notify R1's physician that he had not received any medications including his breathing treatments, (continued on next page)

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	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marigold Rehabilitation and Health Care Center	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.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	diuretics, medication for heart failure or his prednisone. Stated she doesn't know why she did not administer R1's Diamox or Breztri Inhaler on [DATE] or at 8:00 AM on [DATE] despite them being delivered by the pharmacy on [DATE]. Stated she was busy and was going into R1's room at 11:39 AM when R1 was found deceased . Also stated she did not notify nursing management of R1's missing medications on [DATE], [DATE] or at 8:00 AM on [DATE]. R1's (State) Certificate of Death documents R1's Cause of Death as Acute on Chronic Congestive Heart Failure, Acute on Chronic Diastolic Heart Failure with Significant Conditions Contributing to Death as Chronic Obstructive Pulmonary Disease.On [DATE] the surveyor confirmed through interview and record review that the facility took the following actions to remove the Immediate Jeopardy:On [DATE] Director of Nursing has reviewed all residents that are receiving prescribed medications as ordered.On [DATE] Director of Nursing has reviewed all residents, and no residents have been identified to having missed any doses of prescribed medications.On [DATE] All licensed nurses have been educated by the Director of Nursing and provided access on how to obtain unavailable medications from the facilities emergency medication kit (stat safe) On [DATE] Regional Nurse Consultant educated Director of Nursing on medication administration/availability. And as part of QA activities weekly match back audits are completed for med availability. All new admits should be reviewed to ensure their medications are available and orders in place using the checklist. Which is reviewed daily during clinical QA meeting. Licensed Nursing Staff including V5 were educated by Director of Nursing on [DATE] or prior to working their next scheduled shift on the following:Adherence to physician orders Residents should be assessed timely and documentation completed, and the Physician should be notified in the event an ordered medication dose is missed.Facility Nursing Administration notified immediately of any medication administration issue.An audit has been created on [DATE] by the Director of Nursing to ensure compliance with medication administration and availability, assessment and documentation, physician notification and escalation to nursing administration.Director of Nursing or designee will conduct an audit of 3 licensed nurses 3 times per week for 8 weeks to ensure compliance with medication administration standards. Completion date [DATE]

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain an accurate medical record for three of three residents (R1, R2 and R3) reviewed for accuracy of medical records, in a sample of 3. Findings include:1.R1's facility Face Sheet documents that R1 was admitted to the facility on [DATE]. R1's Nursing Progress Notes, dated 10/21/2025 document, 10/21/2025 at (6:19 P.M.) V7 (Advanced Practice Nurse) was notified that (R1) is (a) new admit and medications are not available at this time. (V7) gave order to hold medications that are unavailable.A review of R1's Physician Order Sheet, dated October 2025 does not include a signed physician order to hold R1's medications.2. R2's facility Face Sheet documents that R2 was admitted to the facility on [DATE].R2's Nursing Progress Notes, dated 10/23/2025 at 9:23 A.M. document, Received (physician's) order to hold Abilify, Trelogy and Jardiance until delivery pharmacy contacted to verify for delivery for this evening and all orders are being filled for drop off this evening.A review of R2's Physician Order Sheet, dated October 2025 does not include a signed physician order to hold R2's medications.3. R3's facility face Sheet documents that R3 was admitted to the facility on [DATE].R3's Nursing Progress Notes, dated 10/24/2025 at 9:26 A.M. document, (R3's) medications on hold til (until) available. Was able to get PRN (As needed) Ultram and Lasix out of backup. PCP (V10/Medical Doctor) aware that meds (medications) are on hold. On 01/05/2026 at 2:40 P.M., V2/Interim Director of Nurses verified R1, R2 and R3's electronic medical records contained no signed physician's order to hold R1, R2 or R3's medications that were unavailable. At that time, V2/DON stated the standard of practice that the facility follows for physician's orders is if a licensed nurse obtains a telephone order or a verbal order from a physician, there must be a signed physician order to back it up. At that time V2/DON confirmed that without a signed physician's order, a telephone order or a verbal order was insufficient and void.