

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  03/25/2026
NAME OF PROVIDER OR SUPPLIER  Marigold Rehabilitation and Health Care Center		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)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review the facility failed to transcribe a residents physician order appropriately for one (R2) of eight residents reviewed for medication administration in a sample of 10. This failure resulted in R2 not receiving his anti-neoplastic medication for three days. Findings include: The facility's Medication Administration Policy for Senior Living, undated, documents not in its entirety, Adherence to this Medication Administration Policy is essential to ensure the well-being and safety of our residents. All staff members are expected to follow these guidelines strictly and to report any issues or deviations from the policy. Continuous improvement and open communication are encouraged to uphold best practices in medication administration. This policy applies to all staff members involved in the administration of medication, including nurses, and any other designated personnel who are certified or licensed to pass medications in the state that they are practicing on. 1. All medication orders must be prescribed by a licensed healthcare professional and documented accurately in the resident's medical records. 3. Any changes in medication orders must be documented in the resident's medical record. Recording and Reporting: 2. Any errors, omissions, or incidents related to medication administration must be documented in the clinical record &amp; reported as per facility policy. Quality Assurance: 1. Regular audits and inspections of the medication administration process should be conducted to identify areas for improvement and ensure compliance with policies and procedures. 2. Any identified concerns, or incidents, should be properly investigated, documented, and addressed to prevent recurrence. R2's admission Record documents R2's admitted to the facility on [DATE] and R2's diagnoses on admission include but not limited to Unspecified Fracture of Shaft of Left Tibia, Subsequent Encounter for Closed Fracture with routine healing, Malignant Neoplasm of Prostate, Anemia, Gastro-Esophageal Reflux Disease without Esophagitis, Essential (Primary) Hypertension, Morbid (severe) Obesity due to excess calories, Malignant Pleural Effusion, and Secondary Malignant Neoplasm of Bone. R2's Minimum Data Set assessment dated [DATE] documents R2 has a Brief Interview for Mental Status score of 15/15, indicating cognition intact. R2's hospital discharge orders dated 2/9/26 documents R2 has an order for Abiraterone (anti-neoplastic) 250mg (milligrams) oral tablet: 4 tabs (tablets) orally once a day on an empty stomach. No stop date indicated. R2's Medication Administration Record (MAR) dated 2/1/26-2/28/26 documents an order for Abiraterone Acetate (anti-neoplastic) Oral Tablet 250mg (milligrams) give 4 tablets by mouth one time a day for take with prednisone (steroid)- chemo until 2/24/26 on an empty stomach. MAR also documents that R2 did not receive Abiraterone on 2/25/26, 2/26/26, and 2/27/26 and an order was started on 2/28/26 for Abiraterone Acetate Oral Tablet 250mg give 4 tablets by mouth in the morning related to Malignant Neoplasm of Prostate; Malignant Pleural Effusion in bottle in drawer. On 3/20/26 at 10:30am, V10 (R2's Family) who stated R2 admitted to the facility around 2/12/26 due to sustaining a left ankle fracture. R2 was sent there as they were the only facility that would take him due to her cancer medication, but he has missed several days because nurses keep telling R2 that it is not on his orders to give. V10 stated R2 is to take this medication for the rest of his life due to Stage 3 Prostate Cancer. Not sure exactly how many days he has missed and when but stated R2 would know because he has been keeping track. On 3/20/26 at 2:40pm, R2 stated he has had several (continued on next page)</p>		

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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>days that he has not received his cancer medication; the nurses tell R2 there is no order for it, or they do not have any available. R2 stated he brought in his bottle from home that had a 4-day supply and had it renewed just after he got here. R2 stated it is not one specific nurse because he rarely has the same nurse due to the facility using agency staff. R2 also stated he was told he cannot miss taking it as his prostate cancer has spread to his bones. On 3/24/26 at 8:50am, V15 (Licensed Practical Nurse/Wound Nurse) and V3 (Assistant Director of Nursing) who verified that R2's transcribed orders for Abiraterone show a stop date of 2/24/26. V15 verified she transcribed R2's medication order for Abiraterone (anti-neoplastic) on admission to the facility and V15 also verified that R2's hospital discharge orders did not contain a stop date for the use of his Abiraterone. V15 stated, I'm not sure where that came from. It's not on his hospital discharge order and there is no script in his chart. On 3/24/26 at 9:08am, V16 (Licensed Practical Nurse) who stated, I only changed R2's administration time from 8am to 6am because he (R2) told me that he usually takes it before breakfast at home on an empty stomach. The stop date was already on the order. On 3/24/26 at 2:51pm, V28 (Former Director of Nursing) who stated that R2 voiced concerns that the nurse, could not remember who or what date specifically, would not give R2 his cancer medication because there was not an order for it. V28 stated she re-instated the order as it should never have been stopped. R2 refused to take it that day as it was too late in the day but did resume it the next day.</p>		