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	04/21/2026

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 - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to prevent physical and verbal abuse from happening for five (R1, R2, R4, R5 and R6) of five residents reviewed for abuse in a sample of six. The physical abuse on 3/9/26 between R1 and R2 resulted in R1getting a black eye and ear laceration, and R2 getting a fat lip.Findings include:Facility Abuse, Prevention, and Prohibition Policy, dated November 2025, documents Each resident has the right to be free from abuse. Residents must not be subject to abuse by anyone, including but not limited to staff, and other residents. This facility prohibits mistreatment, neglect, or abuse of residents. Resident to resident abuse includes the term willful. The word willful means that the individuals action was deliberate regardless of whether the individual intended to inflict injury or harm.1.R4 and R5's Final State Report, dated 2/24/26, documents on 2/27/26 R4 reported to facility staff that V10 CNA/Certified Nurse Aide verbally abused R5 in her room. R5 is unable to state if she feels abused due to her cognitive status. V10 admits to being overwhelmed with the amount of work she was assigned. R4 states he has felt V10 has been rude to him when providing care. V10 doesn't take enough time when working with him and felt V10 was rude to other residents. V14 LPN MDS/Minimum data Set stated V10 did appear to be overwhelmed in the performance of her duties. With the potential of (V10) being agitated or stressed while on duty, and thereby allowing any negative occurrence to take place, the facility has chosen not to return her to employment.V10's employee file documents V10 CNA was hired 8/26/24 with a termination 2/27/26 for: Corrective action form dated 2/17/26 (V10) displayed a level of discourteousness towards a facility resident that was out of bounds for normal interactions especially with facility residents. Termination of employment (not eligible for rehire). Educated for dementia care and abuse on 2/26/25.Signed facility resident rights and preventing abuse on 9/13/24 which includes preventing mental, physical, verbal abuse.On 4/17/26 at 3:15PM, V14 LPN MDS/Licensed Practical Nurse Minimum Data Set stated, I was called to (R4) room, and he said (R5) was yelling stop and (V10 CNA) said be quiet and get out of bed. That same day (R4) felt (V10) was rough with him for cares, he felt she was aggressive and loud speaking. I was the nurse working on the hallway that night, I called (V19 Prior Administrator) about (V10) and (V10) was clocked and walked out of the building. I felt (V15) was overwhelmed because she was anxious, agitated, and short tempered.2.R2's electronic nurses note, dated 3/9/26 at 2:06am V9 LPN, documents (R2) was observed in (R1's) bed physically restraining him by his wrist holding him to the bed. (R1) was yelling for help and (R2) was not redirectable. 911 was called. (R2) was given Haldol in the buttocks. (R2) was sent to the hospital for evaluation of his behavior. Police were present.R2's Nurses note, dated 3/9/26 at 2:30AM by V3 DON/Director of Nursing, documents (R2) was heard screaming in his room; (R2) was observed holding (R1's) wrists down pinning him to the bed and screaming in his face; (R2) was insisting (R1) had a gun and was going to hurt him and the staff; staff were able to get (R2) to let go of (R1); (R2) was not able to be redirected; (R2 was given Haldol IM/Intramuscular but it was not successful; and (R2) sent to the ER/emergency room for further evaluation at the hospital.R1's electronic nurses note, dated 3/9/26 at 2:30AM by V3 DON documents (R2) was observed on top of (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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F 0600 Level of Harm - Actual harm Residents Affected - Few	(R1) screaming in his face and saying (R1) had a gun and was going to hurt everyone. Staff was able to get (R2) off (R1) and out of the room. Staff remained in the doorway so (R2) could not get into the room with (R1), and once (R2) was sent out of the nursing home (R1) was able to lay back down and rest.R1's electronic skin notes, dated 3/9/26 at 10:24AM by V15 LPN, documents New skin issue to right eye. Below right eye, above cheek bone bruising, wound acquired in house on 3/9/26. Length 3cm/centimeters by width 5cm. On 3/9/26 at 12:14PM, V15 documents new skin issue right ear. Length 1.58cm by width 2.5cm and area 3.17 (cm2).R1 and R2's final State Report, dated 3/13/26, documents on 3/9/26 in residents' room a physical interaction between R1 and R2 took place. Redness noted to skin for both residents where they had come into physical contact with each other. R2 was noted to have a cut on his lip and scratch by his left eye. R1 was noted to have redness around the area of his wrists. V9 LPN/Licensed Practical Nurse stated R2 was lying over R1 holding on to R1's wrists and wouldn't let go. V7 CNA/Certified Nurse Aid working on the unit confirmed V9 facts.On 4/17/26 at 12:15PM, R1 was alert, in a manual wheelchair, unable to answer questions/confused, jumbled speech, and was talking/muttering to himself. R1's right eye had a moon shaped bruise purple/pink underneath eye, and his left eye purple under eye extends to cheek which has a greenish colored bruise.On 4/17/26 at 12:15 PM, R2 was in the dining room, alert, got up and walked independently to the hallway, confused, grabbing stuff off the food cart, unable to answer questions, and very busy walking around with staff attempting to redirect and required many attempts at redirection.On 4/17/26 at 12:15PM, V20 Memory Care Supervisor stated (R2) is hard to redirect and keep busy.On 4/17/26 at 12:30PM, V18 CNA stated (R2) has hallucinations; (R1 and R2) were roommates; (R2) talks but not a lot and he is hard to understand; not sure what exactly happened that day just what I was told by the CNA.On 4/17/26 at 12:40PM, V17 CNA stated (R1) [NAME] and talks to himself a lot all the time.On 4/17/26 at 12:50PM, V18 CNA stated (R1's) left eye was black and (R2) had a fat lip. What I understood was (R2) was holding (R1) down, they were going at it fighting. (R2) was really hard to re-direct, he still takes coaxing. (R2) sometimes freaks out and runs for the door to get out and pound on the door.On 4/17/26 at 3:00PM, V12 RN stated R2 has a history of running into doors and hitting unprovoked.3. R2's Final State Report, dated 3/11/26, documents Alzheimer's/Dementia Care Area of Facility on 3/4/26 V12 RN ADON/Assistant Director of Nursing communicated to V19 Prior Administrator V13 CNA had spoken inappropriately to residents on the Alzheimer's/Dementia Care Area. The residents living in that area are unable to state if they felt verbally abused due to their cognitive status. V12 RN ADON reported she felt V13 CNA had communicated with the residents in a concerning tone. V20 Supervisor of Alzheimer's/Dementia Unit stated V13 appeared to be overwhelmed in the performance of her duties. V17 CNA stated V13 did display a feeling of being overwhelmed and stressed which appeared to be caused by her workload. With the potential of (V13) being agitated or stressed while on duty, and thereby allowing any negative occurrence to take place, the facility has chosen not to return her to employment.V13's employee file documents V13 PTA/Physical Therapy and CNA last day worked was 3/4/26. V13 signed facility resident rights and preventing abuse on 2/12/24 which includes preventing mental, physical, verbal abuse.On 4/17/26 at 3:00PM, V12 RN stated Me and (V14 LPN) walked (V13 PTA/Physical Therapy Aid) out on 3/4/26, I was the ADON at the time. I was walking back to the memory care unit and staff said, You have got to do something about her she is yelling. When I went back to the unit V13 had her voice raised. (R2) was standing there and lots of other residents.4. R2's electronic nurses note, dated 3/24/26 at 1:15PM by V16 RN/Registered Nurse, documents CNA informed me that (R2) had grabbed (R6's) left arm and would not let go.R2 and R6's Final State Report, dated 3/31/26, documents on 3/24/26 on the Alzheimer's/Dementia Care Area of Facility a physical interaction between (R6) and (R2) took place in the Alzheimers/Dementia Care area. V16 RN was a witness to the interaction stated (R2) grabbed (R6's) left arm. V17 and V18 both CNAs confirmed V16's report.