

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 08/22/2024
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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>31682</p> <p>Based on record review and interview the facility failed to answer call lights timely for 11 of 11 residents (R8, R20, R26, R38, R40, R54, R59, R60, R63, R64, and R66) reviewed for call light response time in the sample of 33.</p> <p>Findings include:</p> <p>The Residents' Rights for People in Long-Term Care Facilities policy (undated) documents, Your facility must provide services to keep your physical and mental health and sense of satisfaction.</p> <p>On 08/21/24 at 10:04 AM, during a resident council meeting R8, R20, R26, R38, R40, R54, R59, R60, R63, R64, and R66 all stated they do not get their call lights answered timely.</p> <p>On 08/21/24 at 10:05 AM, R59 stated, I turn on call light and no one comes at all, and I have to hunt them down. I needed oxygen one day and I got it fixed myself and had to get out of my bed and do it myself.</p> <p>On 08/21/24 at 10:08 AM, R54 stated, On all shifts it will sometimes take over two hours for staff to come to answer my call light. Sometimes staff do not come and help at all. Three times a week I wait on my call light to be answered over two hours or it does not get answered at all. I have reported this in resident council, and I am told (V1/Administrator) will talk to the staff about it.</p> <p>On 08/21/24 at 10:11 AM, R60 stated, The staff come in and turn the call light off and do not come back in. This happens three to four times a week. I need the restroom and they do not get to me.</p> <p>On 08/21/24 at 10:13 AM, R64 stated, I do not get help getting dressed. I only have one leg. Two or three times a week it takes staff over a half an hour to answer my call light and get me dressed.</p> <p>On 08/21/24 at 10:15 AM, R38 stated, It takes staff over two hours about twice a week to answer my call light. I usually need to be taken to the bathroom to get changed.</p> <p>On 08/22/24 at 9:42 AM, V5 (Regional Director of Operations) stated, We (the facility) do not have a policy on answering call lights. Residents' needs should be met whenever a resident turns on their call light.</p> <p>(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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	08/22/24 11:42 AM V1 (Administrator) stated, All call lights should be answered within 30 minutes. All staff should answer call lights.		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>33985</p> <p>Based on interview and record review the facility failed to provide the Resident and/or Resident Representative with a written notice of hospital transfer for one of one resident (R83) in the sample of 33.</p> <p>Findings Include:</p> <p>R83's Census Profile, dated 6/3/2024, documents that R83 had a hospital unpaid leave from 6/3/24 through 6/5/2024 and 6/22/2024. Evidence of a facility notification to R83 of a written notice of transfer or discharge was not present in R83's chart.</p> <p>On 8/22/2024 at 11:35 am, V20/SSA (Social Service Assistant) stated, I do not see where there is any documentation or evidence that R83 or R83's Representative was given a written notice of the transfer or discharge.</p>

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>33985</p> <p>Based on interview and record review, the facility failed to provide a copy of the Bed Hold Policy for Residents who are discharging to the hospital for one of one resident (R83) reviewed for bed holds in a sample of 33.</p> <p>Findings Include:</p> <p>The facility policy, named Bed Hold Policy and Agreement Form, revised 2/2024, documents the following: It is the policy of the Management Company that the facility will establish a system to notify the Resident/Responsible party/Resident Representative of the facility bed hold policy; Procedure: The Bed Hold Agreement is to be obtained for each/occurrence, hospital, or therapeutic leave.</p> <p>R83's Progress Notes, dated 6/22/2024 at 11:40 am, documents the following: Staff entered R83's room and R83 had a clock in her hands with the glass all broken up. R83 kept saying she needed it to cut herself. Staff attempted to get it away from R83 when she threw it at staff. R83 then threw her hamper. Antipsychotic medication (Haldol) given in the right arm. R83 stated, she will break the glass in the window if she needs to.</p> <p>R83's Progress Notes, dated 6/22/2024 at 10:34 pm, documents, R83 has been admitted to the local hospital with a diagnosis of Dementia with Agitation. Pending placement in a geriatric psychiatric facility.</p> <p>On 8/22/2024 at 11:32 am, V20/SSA/Social Service Assistant stated, I was told that the nurse is to give the Resident and/or Resident representative a copy of the Bed Hold Policy. And that the nurse that is doing the transfer is to document that the bed hold was given. I do not see where the Bed Hold was given to (R83/or representative). Nothing is documented.</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31682</p> <p>Based on record review and interview the facility failed to obtain a level II PASRR (Pre-Admission Screening and Resident Review) screening for one of three residents (R67) reviewed for a new diagnosis of mental illness in the sample of 33.</p> <p>Findings include:</p> <p>R67's Face Sheet documents R67 was admitted to the facility on [DATE].</p> <p>R67's PASRR Level I Screen Outcome dated 6-21-22 documents, PASRR Level I Determination: No Level II Required. No SMI (Severe Mental Illness)/ID (Intellectual Disability)/RC (Related Condition).</p> <p>R67's Progress Notes dated 7-6-23 and signed by V6 (Nurse Practitioner) document, New evaluation: Schizophrenia. [AGE] year-old with Disorganized Schizophrenia who is delusional and can get upset and have outburst or attempt to elope form the facility when he is upset.</p> <p>R67's Medical Record does not include evidence of a level II PASRR screening being obtained after R67 was diagnosed with Disorganized Schizophrenia.</p> <p>On 08/21/24 at 02:00 PM V5 (Regional Director of Operations) stated, The facility did not request a PASRR Level II once (R67) was diagnosed with Disorganized Schizophrenia.</p>

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33975</p> <p>Based on record review and interview the facility failed to assess and identify potential triggers and failed to provide specific personalized interventions for one (R44) of three residents reviewed for mood and behavior in a sample of 33.</p> <p>Findings include:</p> <p>Facility Trauma Informed Care Policy, dated 10/2022, documents: the policy of the Facility is to consider Residents past traumatic experiences in developing person-centered care plans designated to avoid re-traumatization through the application of the principles of trauma-informed care; individual trauma results from an event, series of events or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and has lasting adverse effects on the individual's functioning and mental, physical, social, emotional or spiritual well-being; an approach to delivering care that involves understanding, recognizing and responding to the effects of all types of trauma and avoiding re-traumatization; trigger is something that causes the survivor to remember the traumatic event and induces a reaction like when they were originally traumatized and triggers can re-traumatize survivors; safety to create an environment that protects from physical harm and promotes a sense of emotional security; during the admission process, Resident's/Resident Representatives are given the opportunity to answer questions regarding trauma and to discuss their experiences to the extent they are comfortable; and Care Plan with the Interdisciplinary Team to assess the Resident's needs to identify triggers and interventions to eliminate/mitigate triggers that may cause re-traumatization.</p> <p>R44's Physician Order Sheet, dated 8/21/24, documents an admission to the facility on [DATE] and a diagnosis of Post Traumatic Stress Disorder/PTSD.</p> <p>R44's Preadmission Screening and Resident Review/PASRR, dated 1/16/24 documents R44's diagnosis of PTSD.</p> <p>R44's Psychotropic Medication Consent, dated 4/10/22, documents a Physician Order for the medication (Depakote) for a diagnosis of PTSD.</p> <p>R44's Trauma Informed Care form effective 8/10/24, does not document R44's PTSD triggers or interventions.</p> <p>R44's current Care Plan documents, an initiation date (8/31/23) and a revision date (6/3/24), that R44 takes psychotropic medications due to impulse disorder, PTSD and unknown psychosis, depression, and Bipolar Disorder. R44's Care Plan does not document identified triggers or interventions for R44's PTSD.</p> <p>On 8/22/24 at 9:30 am, V5 (Regional Director of Operations) stated, When we took over this Facility in receivership, we updated some of the computer forms and I am not sure why the triggers are not documented on (R44's) Trauma Informed Care form. I do not see that we have any documented anywhere. We did just update (R44's) Care Plan today to identify the triggers.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31682</p> <p>Based on observation, interview, and record review the facility failed to document behaviors to justify the use of antipsychotic medications, obtain a consent prior to the use of an antipsychotic medication, and perform an annual gradual dose reduction of scheduled antipsychotic medications for two of four residents (R10 and R67) reviewed for antipsychotic medication use in the sample of 33.</p> <p>Findings include:</p> <p>The facility's Psychotropic Medication Use policy dated 09/2022 documents, Residents will only receive psychotropic medications when necessary to treat specific conditions for which they are indicated and effective. Prior to starting psychotropic medications, informed consent will be obtained from resident/representative per state guidelines. Antipsychotics medications shall generally be used only for the following conditions/diagnoses as documented in the record, consistent with the definitions in the Diagnostic and Statistical Manual of Mental Disorders a. Schizophrenia b. Tourette's Disorder c. Huntington Disease. Diagnoses alone do not warrant the use of psychotropic medications.</p> <p>The facility's Pharmacy policy of Gradual Dose Reduction (GDR) for Psychotropics dated 2023 documents, The State Operations Manual states after initiating or increasing the dose of a psychotropic medication, the behavioral symptoms must be reevaluated periodically to determine he potential for reducing or discontinuing the dose based on therapeutics goals and any adverse effects or functional impairment. CMS (Centers for Medicare and Medicaid Services) does not provide any exception for GDR for residents under hospice care.</p> <p>1. R10's MDS (Minimum Data Set) assessment dated [DATE] documents R10 is severely cognitively impaired and R10's behaviors do not put R10 or others at risk for physical illness or injury, do not interfere with R10's care, do not interfere with R10's participation in activities or social interactions, do not intrude on the privacy or activity of others, and does not disrupt care or the living environment of others.</p> <p>R10's PASRR (Pre-Admission Screening and Resident Review) Level I Screen Outcome dated 10-11-23 documents, No Level II Required. No SMI (Severe Mental Illness)/ID (Intellectual Disability)/RC (Related Condition).</p> <p>R10's Medication Review Report dated 8-20-24 documents, Order date: 9-25-23 ABH (Ativan/Benadryl/Haldol) gel 1/25/1 (milligrams) one time a day every other day at 5:00 AM for the diagnosis of Unspecified Dementia with unspecified severity with other behavioral disturbance. Order date: 9-25-23 ABH gel 1/25/1 (milligrams) one time day every day at 4:00 PM for the diagnosis of Anxiety Disorder.</p> <p>R10's Medical Record does not include a consent for the use of R10's ABH cream or a Care Plan for the use of R10's ABH cream.</p> <p>On 08/20/24 9:23 AM and 08/22/24 at 10:26 AM, R10 was lying in a low bed. No behaviors noted. R10's bed was against the right side of the wall and mats to floor on left side.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 08/20/24 at 9:34 AM V4 (CNA/Certified Nursing Assistant) stated, (R10) does not have behaviors that cause herself or others harm. (R10) only grabs at staff during cares and talks to God. (R10) can be easily re-directed.</p> <p>On 08/20/24 at 10:25 AM V10 (LPN/Licensed Practical Nurse) stated, (R10) refuses cares. Really that is her only behavior.</p> <p>On 08/22/24 at 10:15 AM V15 (Care Plan Coordinator) stated according to R10's MDS R10's gel contains R10's behaviors do not put R10 or others at risk for physical illness or injury, do not interfere with R10's care, do not interfere with R10's participation in activities or social interactions, do not intrude on the privacy or activity of others, and does not disrupt care or the living environment of others. V15 also stated R10 does not have a care plan addressing R10's use of an anti-psychotic (Haldol) gel. The facility did not obtain a consent for the use of (R10's) ABH cream. Consents for the use of anti-psychotic medications should be obtained by the resident's representative before administration.</p> <p>2. R67's PASRR Level I Screen Outcome dated 6-21-22 document, PASRR Level I Determination: No Level II Required. No SMI (Severe Mental Illness)/ID (Intellectual Disability)/RC (Related Condition).</p> <p>R67's Progress Notes dated 7-6-23 and signed by V6 (Nurse Practitioner) documents, New evaluation: Schizophrenia. [AGE] year-old with Disorganized Schizophrenia who is delusional and can get upset and have outburst or attempt to elope form the facility when he is upset. Increase Haldol from 25 mg to 50 mg.</p> <p>R67's Order Summary Report dated 8-21-24 documents, Order date: Haldol Decanoate IM (Intramuscular) 100 mg (milligrams)/ml (milliliter) 75 mg one time monthly for the diagnosis of Disorganized Schizophrenia.</p> <p>R67's Medical Record does not include a consent for the use of R67's Haldol Decanoate IM, a Care Plan for the use of R67's Haldol Decanoate, or a gradual dose reduction attempt of R67's Haldol Decanoate since 7-6-23.</p> <p>On 08/20/24 at 9:34 AM V4 (CNA/Certified Nursing Assistant) stated, (R67) does not have any behaviors.</p> <p>On 08/22/24 at 10:15 AM V15 (Care Plan Coordinator) stated, (R67) does not have behaviors to justify the use of Haldol. (R67) receives hospice services and only really wants to go to bed. (R67) has not had a gradual dose reduction attempt in the last year. (R67) does not have a care plan to address the use of Haldol. The facility did not obtain a consent for the use of Haldol IM every month.</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p>31682</p> <p>Based on record review and interview the facility failed to provide bedtime snacks for 11 of 11 residents (R8, R20, R26, R38, R40, R54, R59, R60, R63, R64, and R66) reviewed for bedtime snacks in the sample of 33.</p> <p>Findings include:</p> <p>The facility's Dining Service Mealtimes policy (undated) documents, Procedure: Meals and snacks will be served at the following times: HS (Hour of Sleep) Snack 8:00 PM. An HS snack must be offered to all residents.</p> <p>The facility's Diagnosis Report dated 8-21-24 documents R20, R38, R40, R59, R60, R63, R64, and R66 all have the diagnoses of Type II Diabetes Mellitus.</p> <p>On 08/21/24 at 10:04 AM during a resident council meeting R8, R20, R26, R38, R40, R54, R59, R60, R63, R64, and R66 all stated they do not get provided with bedtime snacks.</p> <p>On 08/21/24 at 02:12 PM V13 (Agency CNA/Certified Nursing Assistant) stated, I have worked here since February. Only part of the residents on the hallways are offered bedtime snacks.</p> <p>On 08/21/24 at 02:22 PM V13 (Agency CNA) stated she works second shift at the facility. V13 also stated not all the residents are offered a bedtime snack.</p> <p>On 08/22/24 at 09:42 AM V5 (Regional Director of Operations) stated, All residents should be offered bedtime snacks.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>38805</p> <p>Based on observation, record review and interview, the facility failed to follow its policy and ensure sanitary handling of food items during mealtimes. This failure has the potential to affect all 75 residents who reside in the facility.</p> <p>Findings include:</p> <p>The Facility's Hand Washing and Glove Usage Policy, undated, documents: All employees will use proper hand washing procedures and glove usage in accordance with State and Federal Sanitation Guidelines. 5. Gloves are to be used whenever direct food contact is required.</p> <p>The facility's Infection Prevention and Control Manual Standard Precautions Gloves Policy, dated 2019, documents: Purposes: 3. To reduce the likelihood that healthcare workers will transmit their endogenous microbial flora to residents.</p> <p>On 8/20/24 at 11:40 am, V16 (Certified Nursing Assistant/CNA) prepared food trays for all residents residing in the facility. V16 (CNA) removed bread from a plastic bag on a meal tray with V16's bare hands, placed the bread in V16's left hand and used a knife to butter the bread, cut the bread in half, and then placed the bread back on the meal tray with the rest of the food items. No gloving or handwashing was performed.</p> <p>On 8/20/24 at 11:40 am, V16 CNA stated, No, we are not supposed to touch bread or the food with our bare hands.</p> <p>On 8/20/24 at 11:45 am, V17 (Activities) stated, I do not touch the food; we are not supposed to touch the food with our bare hands.</p> <p>On 8/20/24 at 11:55 am, V18 (Licensed Practical Nurse/LPN) stated, Staff should have gloves on if touching residents' food.</p> <p>The facility's Long-Term Care Facility Application for Medicare and Medicaid (Centers for Medicare and Medicaid Services/CMS 671) form, dated 8/20/24, documents 75 residents reside in the facility.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>30722</p> <p>Based on observation, interview, and record review the facility failed to implement Enhanced Barrier Precautions (EBP) for residents with open wounds and indwelling medical devices for four of 12 residents (R2, R19, R54 and R65) reviewed for EBP in a sample of 33.</p> <p>Findings include:</p> <p>Policy titled Infection Prevention and Control Manual-Enhanced Barrier Precautions, undated, documents: Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO's) in nursing homes. Enhanced Barrier Precautions involve gown and gloves during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk for MDRO acquisition (such as residents that have wounds or indwelling medical devices).</p> <p>This Infection Prevention and Control Manual-Enhanced Barrier Precautions Policy, undated, also documents Enhanced Barrier Precautions are recommended for residents with any of the following: 1) Infection or colonization with a MDRO or 2) A wound or indwelling medical device, even if the resident is not known to be infected or colonized with a MDRO. Indwelling medical devices include central venous catheters, urinary catheters, feeding tubes, tracheostomies/ventilators. High contact resident care activities where a gown and gloves should be used include: bathing/showering, transferring residents from one position to another (for example, bed to wheelchair), providing hygiene, changing bed linens, changing briefs or assisting with toileting, caring for or using an indwelling medical device, performing wound care.</p> <p>1. R19's Medication Review Report, dated 08/21/24, documents R19 has an Arteriovenous Fistula and receives Dialysis.</p> <p>On 08/20/24 at 9:46 am, R19 was in R19's room There were no gowns inside or outside of R19's room. There were no gowns discarded in the trash can. There was no Enhanced Barrier Precaution sign posted on R19's door.</p> <p>2. R54's Medication Review Report, dated 08/21/24, documents R54 has wounds to the Left Lateral Thigh and Left Lower Leg.</p> <p>On 08/20/24 at 9:35 am, R54 was observed lying in bed asleep with a dressing to R54's left lower extremity. There was no personal protective equipment inside or outside of R54's room. There were no gowns discarded in R54's trash. There was no Enhanced Barrier Precaution sign posted on R54's door.</p> <p>3. R65's Medication Review Report, dated 08/21/24, documents R65 has an Indwelling Urinary Catheter.</p> <p>On 08/20/24 at 9:51 am, R65 was observed lying in bed asleep with a indwelling urinary catheter bag hanging on the left side of R65's bedframe.</p> <p>(continued on next page)</p>		

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 08/22/2024
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>There were no gowns inside or outside of R65's room. There were no gowns discarded in R65's trash can. There was no Enhanced Barrier Precaution sign posted on R19's door.</p> <p>4. R2's Diagnosis List, dated 6/13/2022, documents, a diagnosis of Flaccid Neuropathic Bladder.</p> <p>R2's Physician's Order Sheet, dated 8/20/2024, documents, Urinary Catheter Sixteen (16) French Ten Cubic Centimeter (10 cc) bulb to hang to gravity. Change monthly and as needed.</p> <p>R2's Care Plan, dated 1/22/2024, documents the following, (R2) has an Indwelling Urinary Catheter related to Flaccid Neuropathic Bladder.</p> <p>On 8/20/2024 at 8:45 am, R2 is lying in bed and R2's Indwelling Urinary Catheter in place, draining amber colored urine with sedimentation in tubing.</p> <p>On 8/20/2024 at 8:45 am, R2 was not in Enhanced Barrier Precautions for the Indwelling Urinary Catheter. No signage was present on the door, no receptacle was in the room, and there was no Personal Protective Equipment (PPE) inside or outside of the room for staff to use.</p> <p>On 08/20/24 at 2:32 pm, there were no containers with infection control personal protective equipment in any of the hallways which house residents in the facility.</p> <p>On 08/21/24 at 7:53 am, V11/Licensed Practical Nurse confirmed that V11 was not familiar with and has never received training or in-service on Enhanced Barrier Precautions.</p> <p>On 08/21/24, at 9:27 am, V7/Registered Nurse confirmed that V7 has not received training on Enhanced Barrier Precautions.</p> <p>On 08/21/24 at 9:32 am, V8 and V9/Certified Nursing Assistants both confirmed they are not familiar with and have not received training or in-service by the facility regarding Enhanced Barrier Precautions.</p> <p>On 8/21/2024 at 2:39 pm, V14/Infection Preventionist stated, The residents that have catheters, medical devices, and/or wounds must be placed in Enhanced Barrier Precautions. I do not know why these residents were not placed in Enhanced Barrier Precautions they certainly should have been. I called (V1/Administrator) and told her that these Residents needed to be placed in Enhanced Barrier Precautions.</p>		