STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510010	A. BUILDING: _____ B. WING _____	C 02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANCHOR OF MARION	1501 SANDBAR DRIVE MARION, IL 62959

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comment The surveys IL185060 & IL183905 were both completed together. IL183905 295.3000 Personnel Requirements, Qualifications and Training 295.6000 Resident Rights IL185060 295.6000 Resident Rights	A 000		
A3000	Section 295.3000 Personnel Requirmts, Qualifns, and Trng This Regulation is not met as evidenced by: TYPE 3 VIOLATION Section 295.3000 Personnel Requirements, Qualifications and Training a) The establishment shall have staff sufficient in number with qualifications, adequate skills, education and experience to meet the 24 hour scheduled and unscheduled needs of residents and who participate in ongoing training to serve the resident population. (Section 35(a)(3) of the Act) This Regulation is not met as evidenced by: Based on record review and interview, the Establishment failed to ensure the residents are	A3000		

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A3000	Continued From page 1 monitored, as required, of injuries. This failure resulted in R1's injured areas, from staff physical abuse, to be completely indented in the Establishment's records. Additionally, this failure has probability for all residents with injuries to be incorrectly monitored and documented in the Establishment records. Findings include; During record review, R1's record has documentation present regarding R1 having red altered areas of skin due to direct care staff physical abuse. The record for R1 additionally states 'The 'Observations for R1', an Establishment form dated on 01/08/25, by E4 Nsg, has documented ' Right outer thigh to have red area and 4 (four) elongated 4 (four) areas coming out from larger red area ... Alerted E1, Adm., Skin Assessment and picture(s) provided ... ' The records for R1 did not contain any reproducible evidence of the specific measurements of these red skin areas. During interview with E1, Adm, when E1 was asked if the records for R1's substantiated physical abuse should include specific measurements of the injured areas. E1 responded "Of course."	A3000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: TYPE 2 VIOLATION Section 295.6000 Resident Rights	A6000		

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A6000	Continued From page 2 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; This Regulation is not met as evidenced by; Based on interview and record review; The Establishment failed to ensure the residents are protected against abuse, both verbal and physical abuse. This failure resulted in R1 & R2 sustaining physical abuse by staff, and R3 sustaining verbal abuse by staff. Additionally, this failure has probability for all residents to endure this type of abuse in this Establishment. Findings include: A. During record review, the Individual Service Plan, ISP, dated 12/31/24, identifies R1 as a 97 year old female who has lived at this Establishment since 09/22/2021 in a Memory Care Unit. The ISP for R1 documents that R1 will need staff assistance with most of Activities of Daily Living, which may include; bathing, grooming, dressing, and toileting. The 'Observations for R1', an Establishment form dated on 01/08/25, by E4 Nsg, has documented ' Right outer thigh to have red area and 4 (four) elongated 4 (four) areas coming out from larger red area ... Alerted E1, Adm., Skin Assessment and picture(s) provided ... ' Additional records reveal that E1, Adm., questioned E2, Direct Care Staff, regarding this injury while addressing another similar incident of allegation of abuse. During record review, documentation is present to review of an investigation started and completed regarding	A6000		

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A6000	Continued From page 3 R1's red areas. This allegation was substantiated and revealed that R1 was physically abused by E2. During record review of E2's employee file, E2 was alleged abuse towards R1 on 01/07/25 and then on 01/08/25 the allegation was founded after administration completed a full investigation. Effective immediately E2 was terminated from employment and not allowed to return to facility grounds. During interview with E1, Administrator, E1 confirmed that while initially starting an investigation on R2 for allegations of abuse, R1's new injuries became known, E1 stated that he investigated both of the incidents at once and found that E2 was guilty of both incidents of physical abuse towards two different residents. The local law enforcement was notified, the State of IL, the POA, and primary care physician. Policies were followed, as required. B. During record review, R2's Individual Service Plan, (ISP), dated 12/31/24, identifies R2 as a resident who has resided here since 11/24/21 in the Memory Care unit. The ISP for documents that R2 needs assistance with toileting and uses a walker, and sometimes a wheelchair for mobility. On 01/07/25, E3, Activity Aide, seen E2, Direct Care Staff, DCS yanked R2's arm from toilet transfer bars and slam R2 in her wheelchair. Then E3 immediately informed management of this incident. Then E1, Administer began an investigation of alleged abuse and escorted E2 off grounds, per policy. Nursing Notes, dated 01/07/25, for R2 described no new injuries noted upon examination.	A6000		

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A6000	Continued From page 4	A6000		

Furthermore, records reveal that E1 completed this investigation and the findings are E2's allegation of abuse was substantiated. E1 then informed Illinois Department of Public Health, R2's Power of Attorney, (POA), and local police department. Immediately E2 was terminated from employment and not allowed back on facility grounds.
During record review of E2's employee file, E2 was alleged abuse on 01/07/25 and on 01/08/25, the allegation was founded after administration completed a full investigation. Effective immediately E2 was terminated from employment and not allowed to return to facility grounds.
During interview with E1, Administrator, E1 did confirm that E2 had an allegation of abuse towards R2, E1 stated that this investigation did prove that this allegation is substantiated and E2 was terminated from employment and not allowed on facility grounds. Additionally, E3 was interviewed and did admit to seeing R2 being mistreated and she immediately informed E1 of this situation.

C.

During record review, the Individual Service Plan, ISP, dated 12/31/24, identifies R3 as a female who has resided here, on Memory Care Unit, since 07/28/21 while receiving end of life care. This ISP documents that R3 needs assistance with her Activities of Daily Living, ADL's, from staff and family.
Establishment of documentation for R3, on 01/08/25 states that approx. 1500, (3 PM), E5 Activities Director, AT Dir., witnessed E6, Certified Nuring Assistant, verbal abuse R3. An allegation was made that E6 told R3 to 'shut the hell up' . Then E5, AT Dir, reported this incident to E1, Adm., who started an internal investigation

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A6000	Continued From page 5 immediately with E6 being suspended and escorted off facility grounds until the investigation was completed. The investigation was completed with E6 found guilty of verbally assaulting R3 and E6 was terminated. The Power of Attorney, Illinois Department of Public Health, local police department, and R3's physician informed of this allegation and findings, During interview with E1, Adm., E1 did confirm that E6 had an allegation of verbal abuse towards R3, the investigation was completed and E6 was found guilty of this abuse and was terminated from employment.	A6000		