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 11/20/2025

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

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A 000	Initial Comment Facility Reported Incident IL198536 295.6000 A)1)13) 295.6010 a) C)	A 000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Repeat Type 1 Violation Section 295.6000 Resident Rights a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights: 1) The right to live in an environment that promotes and supports each resident's dignity, individuality, independence, self-determination, privacy, and choice and to be treated with consideration and respect; 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; Based on observation, interview and record review, the Establishment failed to ensure residents are treated with dignity, respect and were free from physical, verbal and psychosocial abuse. This failure resulted in R1 and R2 being verbally and physically abused during a behavior episode. This failure also resulted in R3 being a witness to the abuse. These failures have the substantial probability to cause severe harm to the other residents residing in the Establishment. Findings include:	A6000		

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A6000	Continued From page 1 The Establishment is Licensed for Memory Care. The Establishment's resident roster, undated , documents 47 residents that reside in the facility. The Establishment's Policy and Procedure, titled Resident Rights, dated 6/9/11 documents, "Procedure: Each resident has the right to: * Be free from mental, emotional, social, and physical abuse and neglect and exploitation.* Be treated at all times with courtesy, respect and full recognition of personal dignity and individuality. R1's Service Plan, dated 5/13/25 documents that she is 91 years old and has a history of behaviors, gets paranoid at times and thinks we are poisoning her and can become verbally aggressive with staff and will refuse her med's. R1's Service Plan documents that she is independent with ambulation with the use of her walker. R1's Accident/Incident report, completed on 11/12/25, date and time of incident 11/11/25 7:30 PM documents, the Diagnosis of Unspecified Dementia, Moderate, with behavioral disturbances. R1's Incident report, dated 11/12/2025 documents that on 11/11/2025 R1 was being physically aggressive with peer and staff were attempting to lessen the behaviors by providing 1:1 and as needed medication. The incident report documents that Z1 R1's POA was informed of R1's behavior at that time. Further review of the incident, it is noted that on 11/12/2025, Z1 contacted the E1/Administrator and E2 /RN about concerns of staff treatment of R1 the previous night per video surveillance in	A6000		

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A6000	Continued From page 2 R1's room. R2's Resident Information Sheet documents that he is 87 years old and has the diagnosis of Alzheimer's Disease. R2's Service Plan, dated 9/23/25 documents that his is independent with ambulation without the use of assistive devices. R2's Incident Report, dated 11/12/25 documents, " Following an incident with peer, it was observed on video footage in peers room that R2 was yelled at and forcefully removed from room by staff. " R3's Resident Information Sheet documents that she is 91 years old and has the diagnosis of Dementia. R3's Service Plan dated 6/24/25 documents that she is non verbal. The Establishment's Investigation Summary of the incident 11/11/2025 documents, "Re: Summary of investigation: R1 11/11/2025 Complaint: On 11/12/25, Management was notified by R1's POA of suspected abuse by Nursing staff during care on 11/11/2025 evening shift. POA, Z1 states the Nurse E3, RN was physically aggressive and verbally aggressive with R1 and another resident R2. Z1 also complained that staff were purposely agitating her mother. Z1 notified management that during a conversation between her and E3 where she was notified of R1 having aggressive behavior in common area prior to incident. E3 made the comment, "I didn ' t hit her back", Z1 stated this was concerning so she decided to view the camera footage in R1's room. Z1 stated this is where she witnessed the abuse. Investigation: Management requested that Z1 send over the video surveillance for management to review. The	A6000		

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A6000	Continued From page 3	A6000		

video footage was received via email from POA on 11/12/25.
Review of the footage shows staff member E3/RN yelling, pulling/grabbing R1's arms, and attempting to isolate resident to bed and room. E3 was also observed yelling at R2 and forcibly pulling him out of the room by his arm.
E5/CNA can also be seen with R1 in one of the video clips forcefully pulling resident into her apartment, both E3 and E5 under each arm and placing her on bed then swinging her legs up. E5 was also seen leading other staff into R1's room while R1 is resting in bed, looking at R1, laughing and hurrying out of the room ultimately disturbing resident rest.
While resident was lying in bed, E6/CNA told resident to "Be Quiet!" after R1 was heard expressing profanities. E4/DSW was verbally aggressive with resident stating "If you hit me, I swear to God! Hit me. Go ahead and hit me. I'm not playing!" in a threatening manner as resident was crossing the room.
E8/DSW and E7/training DSW were observed as bystanders throughout the video footage."

On 11/19/2025 between 1:00PM-1:30 PM E1/Administrator and E2/RN sat down and reviewed 14 video clips of the incident on 11/11/2025 beginning at 6:44 PM -7:15 PM. Upon review of the video clips, the surveyor observed the events written in the investigation summary presented. E3 and E4 were observed E3 was observed during this time being Physically abusive by forcefully grabbing R1's wrist and forcibly pulling R2's right arm escorting him out of R1's room. E3 was also verbally aggressive with R1 and R2 during this observation. E3 yelled at R1 to sit down, Yelling at R1 to stop hitting, Yelling not having this today, this is over and to watch your mouth. R1 was observed stating "oh God

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A6000	Continued From page 4 help me, help me." E3 was observed yelling at R2. E4/DSW during this video is also overheard yelling and making verbal threat at R1 "Quit that, if you hit me I swear to God" E6/CNA is overheard yelling "Be quiet" and telling R1 that she is crazy too. During the video surveillance review, it is noted that R3, R1's roommate (R3) was awake and present in her recliner witnessing the verbal and physical abuse of R1 and R2. On 11/20/2025 at 11:05 AM, E1/Administrator confirmed that upon conclusion of the investigation, E3/RN did physically and verbally abuse R1 and R2. E1 confirmed that E5/CNA physically and verbally abused R1. E1 confirmed that E4/Direct Support Worker and E6/CNA also verbally abused R1 on the evening of 11/11/25. E1 also confirmed that R1,R2 and R3 were not treated with respect and dignity during the incident.	A6000		
A6010	Section 295.6010 Abuse, Neglect, and Financial Exploitation Pr This Regulation is not met as evidenced by: Type 1 Violation Section 295.6010 Abuse, Neglect, and Financial Exploitation Prevention and Reporting a) When the establishment has a reasonable belief that a resident has been the victim of abuse, neglect, or financial exploitation, the establishment shall: c) Establishment employees and volunteers are obligated to report abuse, neglect, or financial	A6010		

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A6010	Continued From page 5 exploitation of a resident to the establishment management and to the department. Based on observation, interview and record review, the Establishment failed to ensure staff reported an allegation physical and verbal abuse immediately to the Administrator as per their policy. This failure resulted in R1 and R2 being verbally and physically abused by 4 staff members with two other staff identified as being on lookers to the abuse. This failure also has the substantial probability of severe harm to the residents residing in the Establishment. Findings include: The Establishments resident roster documents 47 residents residing at the facility. The Establishment's Abuse and Neglect Policy, dated 6/9/2011, documents, "Policy: Residents will be free from Abuse and Neglect. In order to ensure the safety and well-being of our resident, (Establishment) will thoroughly investigate EVERY allegation of abuse/neglect. For purposes of this policy, abuse/neglect can include, but is not limited to , physical abuse, mental abuse, sexual abuse, financial exploitation, withholding of services and neglect. (Establishment) will decide what action is appropriate based on the nature, severity and extenuating circumstances surrounding the incident. Our primary goal is to resolve all complaints as soon as possible in order to restore productive and safe working and living atmosphere. Procedure: Prevention. each one of us has a responsibility to keep vulnerable elders safe from harm. Report suspected abuse or neglect immediately. the Mandated Reported Act requires Supportive Living Facilities (SLF) employees to	A6010		

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A6010	Continued From page 6	A6010		

report suspected abuse and neglect.
*Reports of suspected abuse, neglect or financial exploitation in SLF's are to be reported to the local authorities (police department).
*The person suspecting or witnessing the abuse or neglect will initiate an incident report.
*The employee who witnesses or suspects abuse/neglect, he or she is responsible for reporting the abuse/neglect to his or hers supervisor or any other member of the management team.
*If it is found that an employee witnessed or suspected an act of abuse/neglect and did not report it, he or she will be subject to disciplinary action, up to and including termination of employment.

R1's Service Plan, dated 5/13/25 documents that she is 91 years old and has a history of behaviors, gets paranoid at times and thinks we are poisoning her and can become verbally aggressive with staff and will refuse her med's. R1's Service Plan documents that she is independent with ambulation with the use of her walker.

R1's Incident report, dated 11/12/2025 documents that on 11/11/2025 R1 was being physically aggressive with peer and staff were attempting to lessen the behaviors by providing 1:1 and as needed medication.
The incident report documents that Z1 R1's POA was informed of R1's behavior at that time.
Further review of the incident, it is noted that on 11/12/2025, Z1 contacted the E1/Administrator and E2 /RN about concerns of staff treatment of R1 the previous night per video surveillance in R1's room.

R2's Resident Information Sheet documents that

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A6010	Continued From page 7	A6010		

he is 87 years old and has the diagnosis of Alzheimer's Disease. R2's Service Plan, dated 9/23/25 documents that his is independent with ambulation without the use of assistive devices.

R2's Incident Report, dated 11/12/25 documents, " Following an incident with peer, it was observed on video footage in peers room that R2 was yelled at and forcefully removed from room by staff. "

The Establishment's Investigation Summary of the incident 11/11/2025 documents,
"Re: Summary of investigation: R1 11/11/2025
Complaint:
On 11/12/25, Management was notified by R1's POA of suspected abuse by Nursing staff during care on 11/11/2025 evening shift. POA, Z1 states the Nurse E3, RN was physically aggressive and verbally aggressive with R1 and another resident R2. Z1 also complained that staff were purposely agitating her mother. Z1 notified management that during a conversation between her and E3 were she was notified of R1 having aggressive behavior in common area prior to incident. E3 made the comment, "I didn't hit her back", Z1 stated this was concerning so she decided to view the camera footage in R1's room. Z1 stated this is where she witnessed the abuse.
Investigation:
Management requested that Z1 send over the video surveillance for management to review. The video footage was received via email from POA on 11/12/25.
Review of the footage shows staff member E3/RN yelling, pulling/grabbing R1's arms, and attempting to isolate resident to bed and room. E3 was also observed yelling at R2 and forcibly pulling him out of the room by his arm.
E5/CNA can also be seen with R1 in one of the

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A6010	Continued From page 8	A6010		

video clips forcefully pulling resident into her apartment, both E3 and E5 under each arm and placing her on bed then swinging her legs up. E5 was also seen leading other staff into R1's room while R1 is resting in bed, looking at R1, laughing and hurrying out of the room ultimately disturbing resident rest.
While resident was lying in bed, E6/CNA told resident to "Be Quiet!" after R1 was heard expressing profanities. E4/DSW was verbally aggressive with resident stating "If you hit me, I swear to God! Hit me. Go ahead and hit me. I'm not playing!" in a threatening manner as resident was crossing the room.
E8/DSW and E7/training DSW were observed as bystanders throughout the video footage."

On 11/19/2025 between 1:00PM-1:30 PM E1/Administrator and E2/RN sat down and reviewed 14 video clips of the incident on 11/11/2025 beginning at 6:44 PM -7:15 PM. Upon review of the video clips, the surveyor observed the events written in the investigation summary presented. E3 and E4 were observed E3 was observed during this time being Physically abusive by forcefully grabbing R1's wrist and forcibly pulling R2's right arm escorting him out of R1's room. E3 was also verbally aggressive with R1 and R2 during this observation. E3 yelled at R1 to sit down, Yelling at R1 to stop hitting, Yelling not having this today, this is over and to watch your mouth. R1 was observed stating "oh God help me, help me." E3 was observed yelling at R2. E4/DSW during this video is also overheard yelling and making verbal threat at R1 "Quit that, if you hit me I swear to God"
E6/CNA is overheard yelling "Be quiet" and telling R1 that she is crazy too.

On 11/20/2025 at 11:05 AM, E1/Administrator

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A6010	Continued From page 9 confirmed that not one staff member present during the incident on 11/11/2025 between 6:44 PM - 7:15 PM reported the incident to Administration immediately. E1 further stated that she did not become aware until Z1 reported it on 11/12/25.	A6010		