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 07/02/2025

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 Annual Licensure Survey 295.3000 n) 295.5000 f)1) 295.6000 a) Facility Reported Incident of 06/03/25 / IL193821 -295.6000a) Complaint Investigation 2555257 / IL194184 - 295.6000 a) 2555347 / IL194326 - 295.6000 a)	A 000		
A3000	Section 295.3000 Personnel Requirmts, Qualifns, and Trng This Regulation is not met as evidenced by: TYPE 2 VIOLATION Section 295.3000 Personnel Requirements, Qualifications and Training n) Prior to employing any individual in a position that requires a State professional license, the establishment shall contact the Illinois Department of Professional Regulation to verify that the individual's license is active. A copy of the verification shall be placed in the individual's personnel file. (Source: Amended at 28 Ill. Reg. 14593, effective October 21, 2004) Based on interview and record review the facility failed to verify with the Illinois Department of Professional Regulation, an employee hired as Licensed Practical Nurse who is unqualified, unlicensed to perform duties and responsibilities in that position. This failure resulted in E3, an	A3000		

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A3000	Continued From page 1 unlicensed LPN, providing nursing duties without a license to provide these services. In addition, this failure by the Establishment has the probability to affect all the residents residing at this Establishment. Findings include: During record review, the Establishment failed to reproduce evidence of E3, LPN, having a current and active nursing license. Documentation from Illinois Department of Financial and Professional Regulation revealed that E3 did not review her nursing license and the expiration of her license was 02/28/25. During interview with E1, Administrator, E1 confirmed that E3 did not have a current active nursing license and this knowledge was unknown to the new administrator. Additionally E1 confirmed that E3's last day working as a nurse was 06/12/25.	A3000		
A5000	Section 295.5000 Medication Reminders, Supervision of Self Med This Regulation is not met as evidenced by: TYPE 2 VIOLATION Section 295.5000 Medication Reminders, Supervision of Self-Medication, Medication Administration and Storage f) If an establishment provides medication administration or supervision of self-administered medication, the establishment's medication policies and procedures shall be approved by a	A5000		

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A5000	Continued From page 2 physician, pharmacist, or registered nurse and shall address: 1) Obtaining and refilling medication; Based on record review and interview, R3 did not receive the correct dosage of her medication from 05/07/25 until 05/29/25. Findings include: During record review an Establishment form titled 'Medication Error Report' signed and dated 05/30/25 by E2, RN Director, documents that R3 received a medication dosage error. Under 'Description of Error' is written 'new order not updated, res (R3) cont (continued) to receive previous order.' The Individual Service Plan for R3, dated 12/31/24, under 'Medication Needs: All medication administration provide by a RN or LPN.' During interview with E2, RN Dir., E2 confirmed that R3 did have a medication error/dosage from 05/07/25 until 05/29/25 without an adverse reaction.	A5000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: TYPE 2 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	A6000		

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A6000	Continued From page 3 establishment, nor shall a resident forfeit any of the following rights: Based on record review and interview, the Establishment failed to ensure their residents remained in a safe and therapeutic environment. This failure resulted in R1 being able to leave the Establishment without staffs knowledge and then to leave the Establishment grounds. Additionally this failure by the Establishment has the probability for all residents to leave Establishment without staffs knowledge. Findings include: During record review, it was noted that R1 did leave the Establishment and walk off grounds without staff being aware of this activity. On 06/03/25 at 12:16 PM, R1 left the Establishment through the courtyard exit door without staffs knowledge. At 12:19 PM a resident count was completed and R1 was not present. Community people seen R1 walk away from the Establishment and monitored her actions as R1 continued to walk off grounds and in the local area. A community person got in a vehicle to help to continue monitoring R1 and called the Establishment to inform the Establishment of R1's actions and location. A staff member, at a sister Establishment, drove to where R1 was and assisted with returning R1 to her residential Establishment. Then R1 was examined by medical staff to find R1 had no injuries. Additionally, this is the first incident of R1 leaving the Establishment without staff being aware. During interview with E1,Administrator, R1 did leave the Establishment on 06/04/25 at 12:17 PM without staff being aware. R1 left the	A6000		

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A6000	Continued From page 4 Establishment by exiting through the courtyard exit and walked off grounds. At 12:19 on 06/04/25, a resident census was completed with R1 being not on her living unit. During an interview with Z2, a employee at a neighboring business, revealed that she was looking out her office window and seen R1 walk outside at the Establishment and then walk off Establishment grounds. Z2's coworker then got in a vehicle and followed R1 as she continue to walk off grounds and reportedly called the Establishment to report R1 walking off grounds. When asked Z2 if anyone approached R1 in any way while walking, Z2 responded "No, and she (R1) was always in the line of sight."	A6000		