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	ASL510010	A. BUILDING: _____ B. WING _____	C 08/04/2026

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 to 7/25/26 IL203043 Violations cited: Repeat 295.6000 a)1)2)13) 295.4010 a)d)e) Complaint of Original Investigation 2659947/IL203271 Desk Audit resulted in no findings in this survey	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 1 Violation Section 295.4010 Service Plan a) Based on the physician's assessment and establishment evaluation (see Section 295.4000), a written service plan shall be developed and mutually agreed upon by the establishment and the resident. (Section 15 of the Act) The establishment shall respect and accept the resident's choices regarding the service plan. d) The service plan, which shall be reviewed annually, or more often as the resident's condition, preferences, or service needs change, shall serve as a basis for the service delivery contract between the provider and the resident (see Section 295.2030). (Section 15 of the Act) e) The service plan shall be reviewed and revised if necessary immediately after a	A4010		

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A4010	Continued From page 1	A4010		

significant change in the resident's physical, cognitive, or functional condition (see Section 295.4000).

Based on observation, interview, and record review, the Establishment failed to develop and implement interventions upon R1's admission to the Establishment on 4/14/25 after R1 was asked to leave the Establishment he was previously residing at for exhibiting inappropriate sexual behaviors to others working and living at the Establishment, failed to implement any interventions for R1 nor for R2 after R1 was found in R2's room on 4/29/26, failed to implement interventions after multiple Establishment employees observed inappropriate sexual behaviors by R1, and failed to timely implement interventions on R1's Service Plan after R1 was found in R2's room inappropriately touching R2 on 7/25/26. These failures resulted in harm to R2 as she is not a consenting adult due to her poor cognition secondary to her diagnosis of dementia and create substantial probability of harm to all residents of the Establishment.

Findings Include:

R1's Resident Information form dated 7/30/26 documents R1 was admitted to the Establishment on 4/14/25 with a diagnosis of unspecified dementia, mild, with agitation.

R1's Functional Assessment dated 6/27/25 documents R1 scored a 29 out of 30 points indicating R1 is cognitively intact.

R1's Service Plan dated 4/10/25 documents R1 is very social and flirtatious at times. This Service Plan does not document any interventions related to R1's flirtatious behaviors.

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A4010	Continued From page 2 R2's Resident Information sheet dated 7/30/26 documents R2 has diagnoses including dementia, anxiety disorder, and altered mental status. This form also documents R2 is a fall risk and receiving Hospice services for end-of-life care. R1's observation note dated 4/29/26 at 11:30 PM and authored by E4 RN (Registered Nurse) documents R1 entered the room a of female resident R2 while this nurse was giving medication to R2. The female resident R2 voiced discomfort with R1's presence in her room. This nurse attempted to redirect R1 to which he insisted "me and her are buddies, leave us alone, go on now, let us have a chat alone." This nurse continued to try to redirect R1. R1 pushed past this nurse and began trying to take R2's candy. This nurse asked R1 to not take things from other people's rooms. R1 said "she gives me them every day, isn't that right?" to which R2 shook her head in denial of the statement. This nurse asked R1 to come with me to exit the room, to which R1 began pursing his lips and making kissing noises while getting closer to this nurse. This nurse redirected R1 again and convinced R1 to leave R2's room by stating this nurse would bring him a cookie if he would leave. R1 finally exited R2's room with this nurse and was led to the dining room. R2's observation note dated 4/30/26 at 12:30 PM documents resident is experiencing increased anxiety. Resident was shaking and stated that she is "scared." R1's nor R2's Service Plans document any interventions to prevent R1 from entering R2's room after the incident documented on 4/29/26.	A4010		

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A4010	Continued From page 3 R1's observation note dated 7/25/26 at 8:15 AM documents resident was found by care staff within a female resident's room, reaching beneath her blankets, touching her inappropriately while she was sleeping. This RN was notified by care staff member and accompanied the team member due to R1 refusing to listen to her. Upon entering the room, the lights were still off due to the female residents trying to sleep and R1 was still at the side of R2's bed, reaching beneath her blanket and rubbing her thigh from what this nurse could visualize from where the blanket had been lifted by R1. This RN asked R1 to leave the room due to the resident being asleep and explaining to R1 that touching the sleeping resident was not appropriate. R1 stated "she told me too" then turned to the care staff member and looked back at this nurse before stating "oh, don't you go listening to that asshole." This RN repeated request for R1 to leave. R1 repeated "she told me to" louder. This RN stated, "I need you to leave this room." R1 approached this RN and said "I am leaving because I am finished now, not because you told me to." R1 then finally left the room while continuing to claim that R2 asked him to. This RN spoke with R2 in private to console her. R2 was visibly groggy and stated she didn't know why he was doing that and when this RN asked her directly if she had asked him to touch her, she stated "no, thank you for helping me" and held this RN's hand tightly with an expression of distress. R2 was reassured and this RN left room once sure she was calm. On 7/29/26 at 9:50 AM E3 LPN (Licensed Practical Nurse) stated R1 has a history of sexual behaviors as he flirts with staff and other residents.	A4010		

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A4010	Continued From page 4	A4010		

On 7/29/26 at 10:16 AM E5 DSP (Direct Support Person) stated she has heard from other staff that R1 has been sexually inappropriate to the staff and asks them if their underwear matches their scrubs.

On 7/29/26 at 10:25AM E6 DSP stated that she was working on 7/25/26, that R1 had gotten done eating breakfast and they knew R2 was in her room sleeping because R2 didn't come down for breakfast. E6 said she saw R1 go into R2's room and something told her to follow him. E6 stated when she got to R2's room R1 was over by R2's bed and had R1 had his hand under R2's cover but he had it between the two covers R2 had on so R1 pulled his hand out then put it back under both of the covers, so he was touching R2. E6 said that she does not know if R1 had his hand on R2's thigh, leg or feet. E6 said that R1 will go into R2's room often to scratch R2's back, but R2 is usually up in her recliner. E6 said that when she saw R1 was in R2's room that she notified E4 (Registered Nurse) who went into R2's room to get R1 away from R2. E6 said that R2 was upset and told E4 that she didn't like R1 being in her room or touching her and she thanked E4 for getting R1 away from her. E6 said that you could tell that R2 was still a little tired and sleepy. E4 told R1 that R2 was upset and scared because he (R1) was in R2's room while she was sleeping.

On 7/29/26 at 1:52 PM E4 RN (Registered Nurse) stated E6 DSP came to her on 7/25/26 around 8:30 AM and reported she was trying to get R1 to leave R2's room because R1 was touching R2's legs. E4 stated she went down to R2's room and observed R1 rubbing R2's inner thigh near her pubic area. E4 stated R2 was only wearing a shirt and an adult diaper. E4 stated she asked R1 to leave the room and R1 became argumentative

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A4010	Continued From page 5	A4010		

and stated he was not leaving R2's room because I asked him to leave but because he was done. E4 said that she talked to R2 and asked her if she wanted and gave permission for R1 to be touching her and R2 said no she didn't give R1 permission, and you could tell that R2 was still half asleep. E4 said that R2 did thank her, and you could tell R2 was upset about R1 touching her and being in the room. E4 said that R2 wasn't really sure what was even really going on. E4 stated she then locked R2's room so R1 could not go back in there. E4 stated R1 always tries to go into R2's room. E4 said that there was another time back in April of this year when R1 went into R2's room and didn't want to leave and then R1 stole some candy out of R2's room when he did leave. E4 said that R1 has made inappropriate comments to her about R1 wanting to see E4 naked. E4 said that R1 has also made inappropriate sexual comments to other staff as well. E4 said that she doesn't feel like R1 has any problems with memory and that R1 remembers everything. E4 said that R2 said that she felt uncomfortable about R1 rubbing on her thigh, back and shoulders. E4 said that she has been told by staff that R1 has a history of sexual inappropriate behaviors. E4 stated R2 is confused and was unable to provide any details as to what occurred when R1 was in her room. E4 stated R2 was more cognitively intact until a few months ago and in April of this year R2 told her she was uncomfortable with R1 in her room. E4 stated in her professional opinion it was sexual abuse she witnessed when she observed R1 with his hand on R2's inner thigh.

On 7/29/26 at 10:33 AM E8 Activity Director stated R1 is frequently inappropriate with staff, residents, and visitors, especially kids. E8 stated someone had their niece here to visit, she was a

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A4010	Continued From page 6	A4010		

little girl and R1 was chasing her around, someone said the little girl needs changed and R1 said that's what he was going to do. E8 stated R1 frequently touches other residents' hands and whispers in their ears but she can't hear what he is saying. E8 stated R1 was frequently rubbing R2's back up and down at the table.

On 7/29/26 at 11:54 AM E3 LPN stated R1 just went into R2's room, he refused to leave so she continued to tell him he has to leave R2's room then he did and R1 said thank you to her. E3 LPN then went into R2's room along with surveyor and E3 asked R2 if R1 makes her uncomfortable and R2 stated yes but then was unable to elaborate as to why due to her poor cognition.

On 7/29/26 at 1:18 PM E2 DON (Director of Nursing) stated R1's Service Plan was not updated with any interventions related to the incident on 7/25/26 with R1 inappropriately touching R2 until today 7/29/26 after the surveyors entered the Establishment to investigate the incident between R1 and R2 that was reported by the Establishment.

On 7/30/26 at 11:45 AM surveyor observed R1 ambulate up to R2 and quietly voice something to R2 although surveyor could not hear what R1 said.

On 7/30/26 at 11:52 AM E7 CNA (Certified Nurse Assistant) stated to surveyor and R1's nurse E3 that R1 said "do you not want me to go in your room again?" when he spoke to R2 at the dining room table.

On 7/30/26 at 12:08 PM E12 Lead CNA staff stated no one from the establishment ever informed her of R1 having a history of

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A4010	Continued From page 7	A4010		

inappropriate sexual behavior at his previous facility he resided at before being admitted to this Establishment.

On 7/30/26 at 11:56 AM Z2 daughter of R1 stated R1 does have a history of inappropriate sexual behaviors. Z2 stated R1 was asked to leave his last facility because he was inappropriately touching staff and residents. Z2 stated she informed the Establishment upon admission that R1 had been asked to leave his previous facility due to his inappropriate sexual behavior towards others.

On 7/30/26 at 12:11 PM E2 DON stated she was already working at the establishment when R1 was admitted although she was never informed of his history of inappropriate sexual behavior. E2 stated the Social Worker who admitted R1 no longer works at the Establishment. E2 stated no interventions related to R1's inappropriate sexual behaviors were implemented on R1's Service Plan and Care Plan until 7/29/26.

The Establishment's Implementing the Service Plan policy dated 7/2002 documents it is the policy of the Establishment that all Service Plans will be implemented to provide quality care to all residents. Service Plans are developed to fit the individualized needs of each resident. It continues, the Facility Manager, Direct Service Supervisor and Social Service Coordinator will meet on a weekly basis to discuss any changes noted or recognized by staff.

The Establishment's Resident Roster dated 7/28/26 documents there are 51 residents living at the Establishment.

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A6000	Continued From page 8	A6000		
A6000	Section 295.6000 Resident Rights	A6000		

This Regulation is not met as evidenced by:
Type 1 Violation - Repeat 295.6000 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;

2) The right to respect for bodily privacy and dignity at all times, especially during care and treatment;

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 Resident Rights by failing to protect 1 of 6 residents (R2) reviewed for abuse from sexual abuse by another resident (R1). These failures resulted in harm to R2 as she is not a consenting adult due to her poor cognition secondary to her diagnosis of dementia and create substantial probability of harm to all residents of the

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A6000	Continued From page 9	A6000		

Establishment. Additionally, the Establishment failed to implement interventions to ensure R2's safety on 4/29/26 after R2 voiced discomfort with R1 being in her room to staff of the Establishment.

Findings Include:

R1's Resident Information form dated 7/30/26 documents R1 was admitted to the Establishment on 4/14/25 with a diagnosis of unspecified dementia, mild, with agitation.

R1's Functional Assessment dated 6/27/25 documents R1 scored a 29 out of 30 points indicating R1 is cognitively intact.

R1's Service Plan dated 4/10/25 documents R1 is very social and flirtatious at times. This Service Plan does not document any interventions related to R1's flirtatious behaviors.

R2's Resident Information sheet dated 7/30/26 documents R2 has diagnoses including dementia, anxiety disorder, and altered mental status. This form also documents R2 is a fall risk and receiving Hospice services for end-of-life care.

R1's observation note dated 4/29/26 at 11:30 PM and authored by E4 RN (Registered Nurse) documents R1 entered the room a of female resident R2 while this nurse was giving medication to R2. The female resident R2 voiced discomfort with R1's presence in her room. This nurse attempted to redirect R1 to which he insisted "me and her are buddies, leave us alone, go on now, let us have a chat alone." This nurse continued to try to redirect R1. R1 pushed past this nurse and began trying to take R2's candy.

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A6000	Continued From page 10	A6000		

This nurse asked R1 to not take things from other people's rooms. R1 said "she gives me them every day, isn't that right?" to which R2 shook her head in denial of the statement. This nurse asked R1 to come with me to exit the room, to which R1 began pursing his lips and making kissing noises while getting closer to this nurse. This nurse redirected R1 again and convinced R1 to leave R2's room by stating this nurse would bring him a cookie if he would leave. R1 finally exited R2's room with this nurse and was led to the dining room.

R2's observation note dated 4/30/26 at 12:30 PM documents resident is experiencing increased anxiety. Resident was shaking and stated that she is "scared."

R1's nor R2's Service Plans document any interventions to prevent R1 from entering R2's room after the incident on 4/29/26.

R1's observation note dated 7/25/26 at 8:15 AM documents resident was found by care staff within a female resident's room, reaching beneath her blankets, touching her inappropriately while she was sleeping. This RN was notified by care staff member and accompanied the team member due to R1 refusing to listen to her. Upon entering the room, the lights were still off due to the female residents trying to sleep and R1 was still at the side of R2's bed, reaching beneath her blanket and rubbing her thigh from what this nurse could visualize from where the blanket had been lifted by R1. This RN asked R1 to leave the room due to the resident being asleep and explaining to R1 that touching the sleeping resident was not appropriate. R1 stated "she told me too" then turned to the care staff member and looked back at this nurse before stating "oh, don't

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A6000	Continued From page 11	A6000		

you go listening to that asshole." This RN repeated request for R1 to leave. R1 repeated "she told me to" louder. This RN stated, "I need you to leave this room." R1 approached this RN and said "I am leaving because I am finished now, not because you told me to." R1 then finally left the room while continuing to claim that R2 asked him to. This RN spoke with R2 in private to console her. R2 was visibly groggy and stated she didn't know why he was doing that and when this RN asked her directly if she had asked him to touch her she stated "no, thank you for helping me" and held this RN's hand tightly with an expression of distress. R2 was reassured and this RN left room once sure she was calm.

On 7/29/26 at 10:25AM E6 DSP (Direct Support Person) stated that she was working on 7/25/26, that R1 had gotten done eating breakfast and they knew R2 was in her room sleeping because R2 didn't come down for breakfast. E6 said she saw R1 go into R2's room and something told her to follow him. E6 stated when she got to R2's room R1 was over by R2's bed and R1 had his hand under R2's cover but he had it between the two covers. R1 pulled his hand out then put it back under both of the covers, so he was touching R2. E6 said that she does not know if R1 had his hand on R2's thigh, leg or feet. E6 said that R1 will go into R2's room often to scratch R2's back, but R2 is usually up in her recliner. E6 said that when she saw R1 was in R2's room that she notified E4 (Registered Nurse) who went into R2's room to get R1 away from R2. E6 said that R2 was upset and told E4 that she didn't like R1 being in her room or touching her and she thanked E4 for getting R1 away from her. E6 said that you could tell that R2 was still a little tired and sleepy. E4 told R1 that R2 was upset and scared because he (R1) was in

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A6000	Continued From page 12 R2's room while she was sleeping. On 7/29/26 at 1:52 PM E4 RN (Registered Nurse) stated E6 DSP came to her on 7/25/26 around 8:30 AM and reported she was trying to get R1 to leave R2's room because R1 was touching R2's legs. E4 stated she went down to R2's room and observed R1 rubbing R2's inner thigh near her pubic area. E4 stated R2 was only wearing a shirt and an adult diaper. E4 stated she asked R1 to leave the room and R1 became argumentative and stated he was not leaving R2's room because I asked him to leave but because he was done. E4 said that she talked to R2 and asked her if she wanted and gave permission for R1 to be touching her and R2 said no she didn't give R1 permission, and you could tell that R2 was still half asleep. E4 said that R2 did thank her, and you could tell R2 was upset about R1 touching her and being in the room. E4 said that R2 wasn't really sure what was even really going on. E4 stated she then locked R2's room so R1 could not go back in there. E4 stated R1 always tries to go into R2's room. E4 said that there was another time back in April of this year when R1 went into R2's room and didn't want to leave and then R1 stole some candy out of R2's room when he did leave. E4 said that R1 has made inappropriate comments to her about R1 wanting to see E4 naked. E4 said that R1 has also made inappropriate sexual comments to other staff as well. E4 said that she doesn't feel like R1 has any problems with memory and that R1 remembers everything. E4 said that R2 said that she felt uncomfortable about R1 rubbing on her thigh, back and shoulders. E4 said that she has been told by staff that R1 has a history of sexual inappropriate behaviors. E4 stated R2 is confused and was unable to provide any details as to what occurred when R1 was in her room.	A6000		

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 08/04/2026

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

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A6000	Continued From page 13 E4 stated R2 was more cognitively intact until a few months ago and in April of this year R2 told her she was uncomfortable with R1 in her room. E4 stated in her professional opinion it was sexual abuse she witnessed when she observed R1 with his hand on R2's inner thigh. On 7/30/26 at 11:56 AM Z2 daughter of R1 stated R1 does have a history of inappropriate sexual behaviors. Z2 stated R1 was asked to leave his last facility because he was inappropriately touching staff and residents. Z2 stated she informed the Establishment upon admission that R1 had been asked to leave his previous facility due to his inappropriate sexual behavior towards others. The Establishment's undated Resident Rights policy documents it is the policy of the Establishment that all residents will be treated with dignity and respect. The Establishment's Abuse and Neglect Policy dated 3/22/11 documents residents will be free from abuse and neglect. The Establishment's Resident Roster dated 7/28/26 documents there are 51 residents living at the Establishment.	A6000		