STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145027	A. Building B. Wing	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allure of the Quad Cities	833 Sixteenth Avenue Moline, IL 61265

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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 30899 Based on interview and record review the facility failed to ensure one resident (R1) was free of mistreatment of three residents reviewed for abuse. Findings include: Facility Policy/Abuse, Neglect and Exploitation dated 2023 documents: The facility will develop and implement written policies that: Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse. Mental Abuse includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation. Mistreatment means inappropriate treatment or exploitation of a resident. Verbal Abuse means the use of oral, written, or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend or disability. On 6/11/24 at 9:45am R1 stated that V5, CNA (Certified Nurse Assistant) was rough and fast when handling her and disregarded the pain she was in. R1 stated she told her daughter and V1, Administrator and V5 was walked out the next day. R1 stated she did not want V5 to care for her anymore. Final Investigation Report dated 4/29/24 indicates: (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1 reported that V6, CNA was assisting her with the bedpan when V5, CNA came in to assist. Report indicates V5 rolled R1 onto her side and R1 felt as though she was hanging off the bed and was scared. Report indicates R1 reported that V5 is not as gentle with her as other staff and doesn't allow R1 to move at her own pace. R1 reported not wanting V5 to care for her anymore. R1 reported that V5 makes her feel like she is bothering her when she needs help and reported feeling scared when V5 comes into the room because she doesn't know how V5 is going to be. Final Investigation conclusion indicates V5 was terminated due to allegations of abuse. On 6/11/24 at 2:40pm V1, Administrator stated that she also interviewed other residents that V5 was assigned to and found a pattern of discourteous behavior by V5 and a reluctance to provide cares.