

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145027	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2025
NAME OF PROVIDER OR SUPPLIER Allure of the Quad Cities		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>30899</p> <p>Based on observation, interview, and record review the facility failed to prevent the theft of controlled medications for one resident (R2) of three residents reviewed for misappropriation of property in the sample of 15.</p> <p>Findings include:</p> <p>Facility Policy/Abuse, Neglect and Exploitation dated 2025 documents: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Misappropriation of Resident Property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without resident consent.</p> <p>Facility Policy/Controlled Substance Administration and Accountability dated 2025 documents: It is the policy of this facility to promote safe, high quality patient care, compliant with state and federal regulations regarding monitoring the use of controlled substances. The facility shall have safeguards in place in order to prevent loss, diversion, or accidental exposure.</p> <p>Physician Orders indicate R2 had an order dated 1/4/25 for Hydrocodone-Acetaminophen (opioid) 10-325mg (milligrams) Give 1 tablet by mouth every 6 hours as needed for Pain.</p> <p>On 4/28/25 at 11am the above order was changed to Hydrocodone-Acetaminophen Oral Tablet 10-325mg. Give 1 tablet by mouth every 6 hours as needed for Pain to include Do Not exceed 4000mg acetaminophen from all sources per day.</p> <p>(continued on next page)</p>

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
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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Final Investigation Report dated 5/5/25 indicates the allegation of R2's missing narcotics (Hydrocodone) was substantiated. Investigation indicates local Police were notified of R2's missing medications and report filed. All medication carts were searched, and missing narcotics were not found; all other controlled medication counts were correct. Investigation indicates on 4/25/25 V17, RN (Registered Nurse) approached V8, LPN (Licensed Practical Nurse) who was working on the same hall but a different cart and asked V8 for excess medications from her narcotic box on V8's cart to go waste the medications with V2, DON (Director of Nursing). During an investigation interview V17 acknowledged asking V8 for R2's medications from the narcotic box and states she took the medications to V2, DON. Investigation interview with V2 indicates V2 acknowledged that V17 only brought her two bottles of liquid (controlled) medications that belonged to R6 and nothing else. Investigation indicates based on video footage, V17 was seen entering V2's office with a few bottles of medications and an indeterminate number of pill cards and when V17 leaves a few minutes later, V17 is still carrying the pill cards. During the investigation, V17 was asked what she did with the medications/cards and responded that she was unsure what she did with them. Investigation indicates V17 was the last person seen with R2's Hydrocodone and then was unable to account for what happened to the medications. Investigation indicates V17 was terminated from employment. Investigation indicates R2 did not at anytime go without the ordered medication as it was an as needed medication and R2 had not requested the medication.</p> <p>On 5/14/25 at 10:35am video footage dated 4/25/25 between 9am and 11am was reviewed with V3, Regional Nurse and V19, Human Resources Manager and corroborated details of the investigation.</p> <p>On 5/14/25 at 1pm V8, LPN stated that on 4/25/25 sometime between 9am and 11am V17 told V8 she was gathering medications to waste with V2, DON. V8 stated V17 told her - by name - which medications she wanted. V8 stated she was fairly new, wasn't really sure of the facility procedures and gave V17 R2's Hydrocodone medication/cards. V8 stated V17 then proceeded down the hall toward V2's office. V8 stated it was a couple days later and it bothered her about giving the medications to V17, so she called V2 to confirm that V17 had brought the medications to her to waste. V8 stated it was at that time she found out that V17 and V2 had only wasted two bottles of liquid medications and that V17 did not give R2's medications/cards to V2.</p> <p>On 5/15/25 at 11:20am V2, DON stated that on 4/28/25 at 10:47am, she added special instructions to R2's Hydrocodone medication order per pharmacy recommendation. V2 stated that at that time she was unaware that R2's medications were missing. V2 stated on 4/28/25 at 9:20pm she received a call from V18, RN reporting three of R2's Hydrocodone medication cards missing 2 cards with 28 tablets and 1 card with 8 tablets - totaling 64 tablets. V2 stated the search for R2's medications continued but were never found. V2 stated it was determined that V17, RN misappropriated R2's medications based on all of the evidence including video footage of 4/25/25.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30899</p> <p>Based on interview and record review the facility failed to obtain a urine specimen according to physician orders for one resident (R1) of three residents reviewed for implementing physician orders in the sample of 15.</p> <p>Findings include:</p> <p>NP (Nurse Practitioner) Note dated 4/28/25 at 10:22am indicates R1 Complaining of occasional burning pains with urination for a few days. Note indicates R1 has chronic urinary incontinence, chronic overactive bladder and history of UTI's (Urinary Tract Infections). Note Assessment and Plan indicates (obtain) UA (urinalysis) with C&S (Culture and Sensitivity) if indicated.</p> <p>R1's Physician Order dated 4/28/25 indicates Obtain urine sample for UA, C&S. May straight cath(eter) every shift for 2 Days.</p> <p>Progress Note dated 4/30/25 at 12:32am indicates Obtain urine sample for UA, C&S. May straight cath(eter) every shift for 2 Days sample contaminated.</p> <p>Progress Note dated 5/4/25 at 3:50pm indicates UA obtained per straight cath(eter) using sterile procedure, 100ml (milliliters) of turbid, viscous, foul smelling urine returned. (R1's) daughter at bedside and is aware.</p> <p>Laboratory Results Report indicates R1's urine specimen was collected on 5/4/25 at 2:30pm, received by the lab on 5/5/25 at 4:22pm and results reported back to the facility on [DATE] at 2:28pm. Results indicate R1 was positive for a urinary tract infection and also included antibiotics sensitive to the organism identified.</p> <p>On 5/14/25 at 9:15am V9, NP (Nurse Practitioner) stated there was a delay in obtaining the UA for R1. V9 stated the order was to obtain within two days. V9 stated there was only one documented attempt to obtain the UA on 4/29/25, but the specimen was not sent.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>30899</p> <p>Based on interview and record review the facility failed to ensure accurate shift-to-shift controlled medication counts for all residents that had controlled medications stored on the Station C/Front Hall medication cart in the month of April 2025. This failure has the potential to affect 27 residents (R2, R6-R41).</p> <p>Findings include:</p> <p>Facility Policy/Controlled Substance Administration and Accountability dated 2025 documents: It is the policy of this facility to promote safe, high quality patient care, compliant with state and federal regulations regarding monitoring the use of controlled substances. The facility shall have safeguards in place in order to prevent loss, diversion or accidental exposure. Inventory Verification: For areas without automated dispensing systems, two licensed nurses account for all controlled substances and access keys at the end of each shift.</p> <p>Medication Dispense History Report dated 4/1/25 to 4/30/25 indicates R2 and R6 - R41 had controlled medications stored in the Station C/Front medication cart.</p> <p>Narcotic and Controlled Substance Shift-To-Shift Count Sheet for Station C/Front cart dated April 2025 indicates: All resident supply and emergency supply controlled substances must be counted at the end of every shift change.</p> <p>The following Count Sheet dates are missing all or less than the required shift to shift signatures for controlled medication counts: April 1, 2, 3, 4, 7, 10,11,15,16 and 18th.</p> <p>The April Narcotic Count Sheet is blank (no signatures) for the 19th through 30th.</p> <p>On 5/16/25 V2, DON (Director of Nursing) indicated they were unable to find a shift-to-shift count sheet for the C/Front medication cart for April 19th - 30th. V2 stated both of the ADON's (Assisted Director of Nursing) should be monitoring compliance with the controlled substances shift counts.</p>