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	07/20/2025

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

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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	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure one resident (R2) was free from sexual abuse and failed to ensure two residents (R3,R4) were free of physical, resident-to-resident abuse of five residents reviewed for abuse in a total sample of five.The Facility's undated Abuse, Neglect and Exploitation policy 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. Sexual Abuse is non-consensual sexual contact of any type with a resident. R1's Medical Record documents that he was admitted on [DATE] with diagnosis to include but not limited to Dementia, Insomnia and repeated falls. R1's MDS (Minimum Data Set) dated 6/3/25 documents his BIMS (Brief Interview Mental Status) score of 9/15, indicating severe cognitive impairment. R2's Medical Record documents that she was admitted to the facility on [DATE] with diagnosis to include but not limited to Dementia, Muscular Dystrophy and falls. R2's MDS (Minimum Data Set) dated 4/21/25 documents her BIMS (Brief Interview for Mental Status) score of 7/15 indicating severe cognitive impairment. On 7/18/25 at 10:00 AM V1 (Administrator) confirmed that R1 and R2 both reside in the closed Alzheimer's Unit at the facility. The Facility's Final Report dated 6/28/25 documents that R1 was observed with his hand at her (R2)'s front, near the waistband of her pants. R2's Nurse's Note dated 6/20/25 at 9:54 AM documents While waiting for breakfast in the dining room this morning it was noted that a male resident was manipulating resident's genital area over her clothing. Throughout the survey neither R1 nor R2 were able to answer questions appropriately. On 7/20/25 at 9:30 AM V1 (Administrator) confirmed that the facility recognized this instance as sexual abuse of R2 perpetuated by R1. (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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's medical record includes the diagnoses as follows: Alzheimer's Disease; Other Symptoms and Signs involving Cognitive Functions and Awareness and Depression. R3's current Care Plan documents the following under Behaviors: I display behavioral symptoms r/t (related to) dementia and difficulty adjusting to life in long-term facility. Behaviors manifested by wandering and pacing. 7/16/25 Involved in resident-to-resident altercation. R4's medical record includes the following diagnoses: End Stage Kidney Disease (with Hemodialysis) and Dementia. R4's current Care Plan includes the following Abuse/Neglect care plan focus: I am at low risk for abuse/neglect r/t poor cognition. The Goal for this focus is as follows: I will be cared for in a safe manner and verbalize/communicate to staff any incidences of possible abuse. Interventions include: Report any verbalization of abuse/neglect/exploitation to Administrator immediately. An incident report dated 7/16/25 at 10:20pm, by V11 LPN documents: Nurse heard resident wife yelling; went to investigate; Found another resident (R3) in his (R4's) room standing at the head of bed unable to figure out how to leave. (R4) noted rubbing neck. Red marks noted around (R4's) neck. The Resident Description given by R4 states: There was a fight. An additional Incident Report dated 7/16/25 at 10:20pm by V4 LPN/Licensed Practical Nurse, documents the following: Nurse heard yelling, went down hall to investigate. (R3) found in another resident's room standing by head of bed unable to figure out how to get out. (R3) escorted back to his room; sm (small) cut noted to upper lip, scratch noted to left cheek stated, He clocked me good. R3's medical record includes a Progress Note dated 7/16/17 at 11:03pm, by V11 LPN/Licensed Practical Nurse documents the following: 10:20pm, heard a resident yelling Nurse, went to investigate; Found this resident in another resident (R4) room standing at head of bed unable to figure out how to get out; Resident was escorted from room; CNAs (Certified Nursing Assistants) came to assist; Noted other resident (R4) rubbing neck; red marks noted around neck; Cut noted to this resident (R3) upper lip and scratch to left cheek Stated, He clocked me good DON (Director of Nursing) notified; Dr. notified; Messaged left for both (family members/Powers of Attorney) no answer from either; Sitter placed with resident for 1:1. On 7/18/25 at approximately 10:00am V2 DON/Director of Nursing verified R3 and R4 were residents in the facility's secure Memory Care Unit and the incident which occurred in R4's room, on the late evening of 7/16/25, when R3 attempted to choke R4 and R4 struck R3 in the face was resident-to-resident abuse. R3's Incident Investigation folder contained a report, faxed to the state agency on dated 7/17/25, titled Initial Report signed by V1 Administrator/Abuse Coordinator documenting under the heading The Original Allegation: (R3) entered another resident room (R4) last night, staff intervened, and both residents had minor injuries not requiring medical intervention. Both families' notifications were made. Investigation initiated, final five day to follow. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/18/25 at approximately 10:20am, V7 CNA/Certified Nursing Assistant stated she was on duty the night R3 assaulted R4. V7 stated she witnessed the altercation. She stated she heard R4's spouse/roommate yelling from their room, entered the room and saw R3 standing over R4. R3 was assisted out of R4's room and noted facial scratches on R3 as well as a bloody lip. R3 was separated from R4, moved to a different room, on another hall, and a one-to-one observation immediately went into effect. V7 stated it was a little later in the evening when staff noted R4 had abrasions and red marks around his neck and realized R3 had been choking R4 when R3 was in R4's room.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to have documented behaviors to warrant the use of antipsychotic and other psychotropic medications and the facility failed to attempt nonpharmacological interventions prior to using antipsychotic and other psychotropic medications for three residents (R1, R3 and R5) of three residents whose psychotropic medications were reviewed in a total sample of five. The Facility's undated Use of Psychotropic Medication(s) documents It is the intent of this policy to ensure that residents only receive psychotropic medication when other nonpharmacological interventions are clinically contraindicated. Additionally, these medications should only be used to treat the resident's medical symptoms and not used for discipline or staff convenience, which would deem it a chemical restraint. The policy defines Adequate indications for use as refers to the identified, documented clinical rational for administering a medication that is based upon an assessment of the resident's condition and therapeutic goals and after any other treatments have been deemed clinically contraindicated. For psychotropic medications, without documentation in the record explaining that the practitioner has determined that other treatments have been deemed clinically contraindicated, the indication for use is inadequate. Also, adequate indications for use means that the medication administered is consistent with the manufacturer's recommendations and/or clinical practice guidelines, clinical standards of practice, medication references, clinical studies or evidence-based review of articles that are published in medical and/or pharmacy journals. The Facility's undated Restraint free environment policy documents it is the policy of this facility that each resident shall attain and maintain his/her highest practicable well-being in an environment that prohibits the use of physical or chemical restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of such restraints. The policy defines chemical restraint as refers to any drug used for discipline or that makes it more convenient for staff to care for a resident, and not required to treat medical symptoms This include instances when a psychotropic medication may be approved to treat certain symptoms, however, nonpharmacological interventions should be used or attempted, unless clinically contraindicated, because they are less dangerous to a resident's health and safety. The Facility's undated Restraint free environment policy documents Behavioral interventions should be used and exhausted prior to the application of a physical restraint or administration of mediations that could be perceived as a chemical restraint, A physician's order alone is not sufficient to warrant the use of a physical restraint or a medication that could be construed as a chemical restraint. If a medication was initially administered for a medical symptom and continues to be administered in the absence of such symptoms, the facility should re-evaluate the need for such medication to ensure that it does not sedate the resident or make it easier for the staff to care for the resident, causing it to be deemed a chemical restraint. 1.R1's Medical Record documents he was admitted on [DATE] with diagnosis to include but not limited to Unspecified Dementia, severe, without behavioral disturbances, Anxiety, Insomnia and repeated falls. R1's MDS (Minimum Data Set) dated 6/3/25 documents a BIMS (Brief Interview for Mental Status) score of 3 out of possible 15, indicating severe cognitive impairment. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Nurse Practitioner Note dated 6/9/25 documents that resident was being seen because he was readmitted to this facility from the hospital after acute pneumonia. The facility staff have reported increase anxiety and agitation for this resident. R1 is reported as stating he is fine and doesn't need to be seen and that he was upset because he couldn't hear because someone stole his hearing aides and his glasses were lost at the hospital. R1's Physician Order sheet dated June 2025 documents a physician order for Hydroxyzine 25 mg (milligrams) every 8 hours as needed for anxiety/agitation for 14 days. [NAME] Drug Guide for Nurses defines Hydroxyzine as an antihistamine drug that's uses include to help control anxiety caused by dental nervous, and emotional conditions. Other uses: Sedation: can be used to induce sleep before and after surgery. R1's Medication Administration Record dated June 2025 documents that R1 received the 25 mg of Hydroxyzine on 6/12/25 at 9:37 AM. R1's medical record does not contain any documentation related to why R1 received the medication and/or what nonpharmacologic interventions were used prior to the use of a PRN (As Needed) psychotropic medication. R1's Nurse's Note dated 6/22/25 at 11:34 AM documents R1 was physically aggressive and increased agitation and was sent to the Emergency Room. R1 returned from the emergency room with physician orders for hydroxyzine 50 mg (milligrams) three times a day for dementia, and Halodol 5 mg IM (Intramuscular) every 6 hours as needed for agitation for 14 days. R1's Medication Administration Record dated June 2025 documents that R1 received Halodol 5mg IM on 6/29/25 at 7:47 PM. R1's Nurse's Notes dated 6/29/25 at 7:47 PM document that R1 was having vivid hallucination, getting in employees and resident's faces and raising his voice in the main TV area. R1's Medical Record did not document if R1 was redirectable or any nonpharmacologic interventions used prior to the injection of an antipsychotic medication. R1's Physician Order Sheet dated July 2025 documents a new physician order dated 7/6/26 Haloperidol Powder apply 1 mg (milligram) transdermally every 6 hours as needed for unspecified dementia until 7/17/25. R1's Medical Record does not document why this order was obtained on this date. R1's Medication Administration Record for July 2025 documents that R1 received Haloperidol Powder 1 mg transdermally on 7/13/25. R1's medical record did not document what behavior R1 was displaying, if R1 was redirectable or any nonpharmacologic interventions attempted prior to the administration of an antipsychotic medication. R1's current care plan last updated 6/20/25 documents R1 displays verbal/physical aggression towards staff. R1's Intervention/Task for this concern area is Notify (V14/Psychiatric Doctor). Send to ER (Emergency Room) for evaluation. R1's current care plan last updated 6/20/25 documents R1 is resistive/noncompliant with treatment/care (specify) related to: refused medication. R2's Intervention/Task for this concern area is Provide education about risks of not complying with therapeutic regimen. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/20/25 at 10:00 AM V2 (Director of Nursing) confirmed that R1 is severely cognitively impaired and that education would not be an effective intervention for him. V2 confirmed that R1 had no documented nonpharmacolgic interventions on his care plan. 2. R3's medical record includes the following diagnoses: Alzheimer's Disease; Other Symptoms and Signs involving Cognitive Functions and Awareness and Depression. R3's POS/Physicians Order Sheet documents R3 is receiving the following psychotropic medication: Donepezil HCl Oral Tablet 10mg (milligrams): 1 tablet by mouth at bedtime for dementia This order identifies this medication as a Psychotherapeutic/Neurological Agent. R3's current Care Plan dated 7/1/25 documents the following under Behaviors: I display behavioral symptoms r/t (related to) dementia and difficulty adjusting to life in long-term facility. Behaviors manifested by wandering and pacing. And 7/16/25 Involved in resident -to-resident altercation. The following intervention is documented under Interventions/Tasks: Record behavior symptoms and side effects. R3's current Care Plan dated documents, under Behaviors: I display behavioral symptoms r/t (related to) dementia and difficulty adjusting to life in long-term facility. Behaviors manifested by wandering and pacing. 7/16/25 Involved in resident -to-resident altercation. R3's Care Plan includes the following task associated with R3's Behavior Care Plan, documented under Interventions/Tasks: Record behavior symptoms and side effects. On 7/20/25 at approximately 10:45am, V11 CNO/Corporate Nursing Officer stated there was no behavior monitoring documented for R3. R5's medical record documents R5's diagnoses as follows: Bipolar Disorder; Anxiety Disorder and Paranoid Schizophrenia. R5's POS includes orders for the following antipsychotic and psychotropic medications: Zyprexa 7.5 mg (milligrams) one tablet by mouth daily and Seroquel 150 mg orally three times daily Antipsychotics/Antimanic Agents, and Buspirone HCl 15 MG one tablet by mouth three times a day related to Anxiety Disorder. R5's Physicians Orders Sheet also documents an order for staff to observe for and documents the following orders: Monitor for the following behaviors (specify): agitation, delusions, hallucinations, complaints, foul language, psychosis, aggression, refusal of care and Target behaviors: reports or observations of feeling anxious, self-isolating, hallucinations, paranoia, delusions every shift. R5's medical record does not include any behavior monitoring as ordered by R5's Psychiatrist and Primary Physician. On 7/20/25 at approximately 10:45am V11 CNO/Corporate Nursing Officer stated there was no Behavior Monitoring documentation for R5.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review the facility failed to thoroughly investigate an allegation of abuse for one resident (R1) of five residents reviewed for abuse in a total sample of five. The Facility's undated Abuse, Neglect and Exploitation policy 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. Sexual Abuse is non-consensual sexual contact of any type with a resident. Investigation of Alleged Abuse, Neglect and Exploitation: A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigations include: 1. Identifying staff responsible for the investigation: 2. Exercising caution in handling evidence that could be used in a criminal investigation (e.g. not tampering or destroying evidence); 3. Investigating different types of alleged violations; 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses and others who might have knowledge of the allegations; 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation. The Facility's Final Report dated 4/22/25 documents an allegation of verbal abuse of R1 by V7 (Certified Nurse Aide). The allegation documents that V8 (Licensed Practical Nurse) reported that she witnessed an interaction between V7 and R1 that she did not like. V8 reports that V7 (CNA) was clearing the table after a meal and R1 attempted to remove a tray from V7's hands and that V7 and R1 pulled the tray back and forth and that V7 proceeded to yell at resident to get out of the dining room several times while pointing her finger at the door. V7's written statement acknowledges the interaction but states that R1 wanted the half drank milk carton off the the tray the CNA was trying to dispose of. V7's written statement denies V7 yelling at or speaking to R1 inappropriately at all. The investigation did not contain any interviews with other staff members or residents who had worked with V7 previously. On 7/18/25 at 1:30 PM V2 (Director of Nursing) stated she did the interviews for this investigations. I am sure I would have interviewed other people too, V2 could not provide any documentation of any interviews other than the nurse who reported the alleged verbal abuse and the CNA who denied the verbal abuse occurred. On 7/20/25 at 10:00 AM V13 (Chief Nursing Officer) confirmed no further interviews of other staff and residents were available. V13 stated those should have been done and available in the investigation for review.