

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  08/06/2025
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)
F 0684  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals.  (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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review the facility failed to ensure blood pressure monitoring was performed after a change in condition for 1 of 3 residents (R1) reviewed for change in condition in the sample of 3. The findings include: R1's face sheet printed on 7/31/25 showed diagnoses including but not limited to left side hemiplegia and hemiparesis, psychophysiologic insomnia, epileptic syndrome, and cognitive social or emotional deficit following cerebrovascular disease. R1's facility assessment dated [DATE] showed no severe cognitive impairment. The same assessment showed R1 is capable of self-propelling her wheelchair with only supervision or touch assistance from staff. On 7/31/25 at 10:25 AM, R1 was seated in a wheelchair and easily wheeling herself down the hallway using the handrail. R1 was talkative and stated she did recall an incident about a week ago (7/24/25) when she was sitting outside. R1 said the exact details are fuzzy but she remembered staff taking her blood pressure when she was outside. R1 could not recall the temperature or weather that day. R1 said the aide was supervising her and other residents. R1 stated the aide told R1 her blood pressure was low. That was when the activity started. Staff pushed R1 back inside and laid her down in bed. Staff gave R1 fluids and checked her blood pressure again. R1 could not recall who the aide was, any other residents seated outside, or the time of day the incident occurred. On 7/31/25 at 11:20 AM, V3 RN (Registered Nurse) stated she was working on 7/24 on the afternoon shift. V3 said a CNA (Certified Nurse Aide) reported to her sometime around 6:30 PM, that R1 was acting different and seemed altered mentally. V3 said she ran vital signs, and the blood pressure was around 66/40. V3 said R1 was restless, slurred speech, and not herself. V3 stated she called the physician and R1's son. V3 stated R1's son wanted her to stay at the facility. The physician was notified and stated to continue monitoring the resident and to send out if any further declines were noted. V3 said she took R1's blood pressure 4 or 5 more times because it was so low. V3 said she did not know if R1 had been sitting outside in the hot sun earlier or what was going on. V3 said the blood pressure came up a little after laying her down and pushing fluids. V3 said she relayed the situation to the oncoming nurse and left around 11:00 PM. V3 said the oncoming nurse should have continued blood pressure checks and monitoring. V3 said considering R1's history of stroke, vital signs and offering fluids should be done every 30 minutes. That would be a safe and appropriate timeline for monitoring R1. The 7/24/25 oncoming night shift nurse (V5) was attempted to be reached during the survey but did not return any phone call messages. On 7/31/25 at 1:33 PM, V8 LPN (Licensed Practical Nurse) stated residents with a change in condition should be assessed right away, including a full set of vital signs. The physician is notified, and new orders should be carried out. Monitoring a resident includes checking and charting all vital signs and outward physical changes. Residents with a low blood pressure should be offered fluids, repositioned and have the blood pressure rechecked every 30 minutes to one hour. Nurses should be documenting under the vital sign tab or in progress notes of the medical record. No documentation means it was not done. On 7/31/25 at 1:40 PM, V2 (Director of Nurses) stated any resident with a change in condition should be monitored at least every four hours until stable. V2 said R1 did have a low blood pressure on 7/24 which was documented in a progress note at 66/40. The same progress note charted a second blood pressure at 87/46. V2 stated vital signs should have been taken and documented until R1 was stable. V2 said the time and vital sign levels should be recorded. There is no way of knowing if a resident is getting better or declining if it is not done. R1's progress note dated 7/24/25 at 6:51 PM, stated R1 was having altered mental status and speech was slurred. The note showed vital signs were taken and the blood pressure was 66/40. The note showed a second blood pressure was taken of 87/46 (no time documented). The same note showed report given to oncoming nurse to monitor pressure and contact physician of any further changes in condition. The note was authored by V3 (RN). R1's progress note dated 7/24/25 at 7:17 PM, stated resident remained in house and to monitor blood pressure. There was no blood pressure levels or times recorded. The note was authored by V3 (RN). R1's progress note dated 7/25/25 at 4:58 AM, stated will continue to monitor R1. There was no blood pressure levels or times recorded. The note was authored by V5 (LPN). R1's vital signs were reviewed under the electronic charting tab. The most recent blood pressure reading was from May of 2025. On 7/31/25 at 1:14 PM, V1 (Vice President of Operations) stated the only vital signs and blood pressure monitoring for R1 over the last 30 days are those that are in the progress notes. There are none other than those. The facility's Change in a Resident's Condition or Status policy revision dated May 2020 states: 6. The nurse will record in the resident's medical record information relative</p>		