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	03/17/2026

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 - Immediate jeopardy to resident health or safety Residents Affected - Some	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 observation, interview, and record review, the facility failed to protect cognitively impaired residents (R7, R5, R6) from sexual abuse by another resident (R4) with a known pattern of sexually inappropriate behaviors. R4 was observed with her hand on R7's vaginal area. R4 was observed with her whole hand inside R5's pants in his penile area. R4 was observed with her hand in R6's groin moving towards his penile area in a tapping motion up and down. This failure applies to 4 of 13 residents (R4, R7, R5, R6) reviewed for abuse in the sample of 14 and resulted in immediate jeopardy.The Immediate Jeopardy began on 11/22/25 when R4 put a glove on that she took from the nurses' cart, placed her gloved hand onto R7's vaginal area. V16 (Regional Nurse Consultant) was notified of Immediate Jeopardy on 3/13/26 at 3:32 PM. The surveyor confirmed by observation, interview and record review that the Immediate Jeopardy was removed on 3/14/26 but noncompliance remains at level two because additional time is needed to evaluate the implementation and effectiveness of the in-service training.The findings include:R4's face sheet shows R4 was admitted to the facility on [DATE] with diagnoses that include cerebral infarction (stroke) dementia and congestive heart failure (CHF). R4 was on hospice services due to CHF. R4's facility assessment dated show 2/5/26 shows R4 has moderately impaired cognition. R4 uses a wheelchair to self-propel and requires maximum assistance from staff for her activities of daily living (ADL's). On 3/13/26 at 9:45 AM, R4 was sitting in her wheelchair alert and smiling. R4 was away from the male residents in the common area. When asked how she was doing, R4 said she was doing well. 1.R4's progress notes dated 11/22/25 by V5 (Registered Nurse-RN) shows, R4 was observed in hallway having expressions of sexual behaviors. R4 was observed wearing a vinyl glove from nurses' cart. R4 had approached another resident (R7) in same hallway and began to fondle resident's labia. R4 and R7 were separated.R7's face sheet shows R7 was admitted to the facility on [DATE] with diagnoses that include dementia and cancer of the bladder.R7's facility assessment dated [DATE] shows R7 has severe cognitive impairment. R7 is wheelchair bound and dependent on staff for ADLs.During the noon meal, R7 was eating lunch in the same dining room as R4. R7 was unable to answer questions.On 3/13/26 at 12:45 PM V5 (RN) said she was the Nurse on 11/22/25, this incident happened while R4 was in the B wing. On 11/22/25, R4 was sitting in her wheelchair in the B wing hallway. R7 was also sitting in her wheelchair in the B wing hallway. R4 was observed taking a glove from a cart, placed her gloved hand and fondled R7's vaginal area in the hallway. V5 said R4 was taken away from R7 immediately. V5 said she felt bad for R7 who has dementia and was not aware that she was touched inappropriately. When resident touches another resident in their private area, that is sexual abuse. R4 and R7 were now moved in the dementia unit.R4's care plan (undated) did not address this sexual behavior dated 11/22/25 towards R7 with no interventions put in place for R4's sexual abuse to prevent further occurrence of abuse.R7's care plan dated 9/22/25 documents R7 was low risk of abuse with diagnosis of dementia with depression and anxiety. R7's care plan had no updated interventions in place to protect R7 from sexual abuse.2. A Facility Reported Incident dated 2/23/26 as final (with the date of incident as 2/10/26) documents R4 was sitting by R5 and staff observed her (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 - Immediate jeopardy to resident health or safety Residents Affected - Some	with hand near his waist resident immediately separated. R5 was placed on 15-minute checks. R4 was placed on 1:1.R5's face sheet documents R5 was admitted to the facility last 5/9/25 with diagnoses that include dementia, depression and diabetes.R5's facility assessment dated [DATE] shows R5 was severely cognitively impaired. R5 needs assistance with his ADLs due to dementia.On 3/13/26 at 9:50 AM, R5 was sitting in his wheelchair watching TV quietly. R5 said he was fine.On 3/13/26 at 12 PM, V13 (RN) said she was the Nurse in the Dementia unit on 2/10/26. V13 said she was passing the 5PM medications when she looked up and saw R4 wheeling herself fast towards R5. R5 was sitting in his wheelchair. R4 put her whole hand inside R5's pants towards R5's penile area. V13 said she yelled take R4 away from R5 now! When R5 was wheeled away from R4, R4 was so upset yelling and screaming that she wanted to go back to R5. V5 said she notified V3 (Assistant Director of Nursing- ADON) immediately. R4 was placed on 1:1. V13 said R5 had no reaction to what had just happened to him due to dementia but that was sexual abuse. Residents are to be free and protected from any kind of abuse. Residents should be safe.On 3/13/26 at 11:30 AM, V4 (Activity Aide) said on 2/10/26 she heard the nurse screaming to move R4 away from R5. V4 said she saw R4's hand inside R5's pants inside his undergarments touching R5's penile area. V4 said she hurriedly moved R4 away from R5. R4 was upset and she wanted to return to R5. On 3/13/26 at 11:15 AM, V3 (ADON) said it was reported to her regarding R4 having behaviors of sexual aggressiveness when she put her hand inside R5's pants. This was reported to the Administrator (V1) exactly how it happened (R4 touching R5's penile area not just waist). V3 said she instructed staff to closely supervise R4, placing her 1:1 supervision to ensure R4 does not sexually abuse R5 again. V3 said Hospice was also notified.R4's care plan (undated) did not address this sexual behavior dated 2/10/26 towards R5 with no intervention put in place R4's sexual abuse to prevent further occurrence of abuse.R5's care plan dated 2/24/26 documents R5 was moderate risk for abuse related to poor cognition (dementia). R5's care plan had no interventions in place to address R5 being sexually abused last 2/10/26, no interventions in place to protect R5 from sexual abuse.3. The facility's Reported incident sent to the state agency as initial dated 3/11/26 show, there has been a resident-to-resident incident. Residents separated immediately. No injuries and no distress observed. Physician and both POA's notified. 5 days to follow.R6's progress notes dated 3/11/26 shows R4's hand was noticed in groin area outside of clothing on a male resident (R6). Staff immediately intervened and separated them. The other resident (R6) did not appear to be in any distress. She (R4) is now on 15 min checks and will be under increased supervision while in common area.R6's face sheet shows R6 has diagnoses that include Alzheimer's dementia, bipolar disorder and hypertension. R6's facility assessment dated [DATE] shows R6 is severely cognitively impaired.On 3/13/26 at 9:55 AM, R6 was sitting in his wheelchair alert, smiling and had no complaints. On 3/17/26 at 10:32 AM V12 (License Practical Nurse-LPN) said she was the Nurse on 3/11/26 PM shift. It was around 4:30 PM, V4 (Activity Aide) was wheeling R4 towards her. V12 (LPN) said R4 and R6 were both sitting in their wheelchairs side by side. R4 was observed to have placed her hand in R6's groin area towards his private area tapping her hand up and down. Both R4 and R6 were immediately separated. R4 was yelling and screaming while being wheeled away from R6, I want to f---- him! I want to f---k him! I'll do whatever I want to do repeatedly.On 3/13/26 at 11:30 AM, V4 (Activity Aide) said on 3/11/26 it was during activity in the common area, residents were watching TV. R4 and R6 were sitting by each other. R4 had her hand in R6's groin to R6's private area while moving her hand up and down. R6's eyes were wide open looking around as if looking for help. V4 said she immediately moved R4 away from R6 and wheeled R4 towards the Nurse (V12). R4 was so upset yelling repeatedly I want to f--k him, I want to f--k him! R4's care plan (undated) did not address this sexual behavior dated 3/11/26 towards R6 with no interventions put in place regarding R4's sexual abuse to prevent further occurrence of abuse.R6's care plan dated 1/26/26 documents R6 was at high risk for abuse related to diagnosis of dementia, increased vulnerability due to mental health diagnosis of bipolar and PTSD. R6's care plan had no interventions in place to address R6 being sexually abused on 3/11/26, no interventions in place to (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	protect R6 from sexual abuse.On 3/13/26 at 12:30 PM, V6 (RN) said she was the regular Nurse in the dementia unit. R4 came from another hall (B wing), she was moved to the Dementia unit beginning of this year (2026). R4 has been hypersexual, touching other residents in their private areas. R4 was a hospice patient, wheelchair bound and is able to wheel self around. V6 said when R4 placed her whole hand inside R5's pants touching R5's private area on 2/10/26, she was placed on 1:1. R4's monitoring then became every 15 minutes. A few days ago, (3/11/26) R4 again touched another resident R6 in his private area even if she was supposed to be on 15 minutes check. R4 should just have been on 1:1. V6 said R4 has had no new interventions to her sexual behaviors on 2/10/26 or on 3/11/26 incidents. There have been no med changes to address R4's sexual behaviors. On 3/13/26 at 10 AM, V9 (Certified Nursing Assistant-CNA) said R4 was now being kept away from other residents. R4 had been touching other residents in their private areas. R4 has also been heard saying lick my p---y to other residents.On 3/17/26 at 10:08 AM, V14 (Dementia Director/Social Service) said when abuse occurs, a Trauma Assessment should have been done right away to immediately assess the emotional and psychological results of the abuse and help with supportive interventions. V14 said there was no trauma assessments done on R7 (incident on 11/22/25 in B wing), there was no trauma assessment done and R5 (incident on 2/10/26) and there was no trauma assessment done on R6 (incident on 3/11/26).On 3/13/26 at 11:20 AM, V2 (Director of Nursing-DON) said he became DON last 11/2025. V2 said all he knew was R4 has inappropriately touched residents in the dementia unit. On 3/17/26 at 12:04 PM, V1 (Administrator) said she was the Abuse Coordinator and reports all abuse occurrences to the state agency. V1 said she cannot recall the details of what she reported to the state agency regarding R4, R7, R5 and R6. V1 said she was not at the facility to review the reportable incidents she sent to the state agency. (V1 was not at the facility during these investigations.) V1 said sexual abuse was not tolerated at the facility.On 3/13/26 at 3:45 PM, V18 (Regional Director of Operations) said R4, R7. R5 and R6's care plans should have been updated when the incidents happened to ensure proper interventions were put into place. All residents should be safe and free from harm including sexual abuse. V18 said care plans will be updated today-3/13/26.On 3/17/26 at 11:07 AM, V15 Physician regarding R4, R7, R5 and R6, said he was made aware of the sexual abuse of R4 to R7, R5 and R6 last 3/13/26. V15 said he expects the facility to have close supervision of residents to prevent abuse from happening.The facility policy on Abuse, Neglect and Exploitation (undated) documents, it is the policy of this facility to provide protection for the health, welfare and the right of each resident by developing and implementing policies and procedures that prohibit and prevent abuse neglect exploitation and misappropriation of residence property. Abuse means the willful infliction of injury, unreasonable confinement, intimidation or punishment resulting in physical harm, pain or mental anguish which can include staff to resident abuse and certain resident to resident altercation. Instances of abuse of all residents irrespective of any mental or physical condition cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse and mental abuse including abuse facilitated for a neighbor through the use of technology. Sexual abuse-Is a non-consensual sexual contact of any type with a resident. The Immediate Jeopardy that began on 11/22/26 was removed on 3/14/26 when the facility took the following actions to remove the immediacy:R4 was immediately separated from other residents and placed under continuous 1:1 supervision to prevent further inappropriate contact until discharge from facility or her condition warrants immobility.R5, R6 and R7 were immediately assessed by nursing staff for physical injury and psychosocial distress. No physical injuries or psychosocial distress were identified.SSD/Memory Care Director verified all memory care residents have had a risk for abuse assessment completed per policy.The physicians and parties responsible for all residents involved were notified.R4, R5, R6 and R7 had an Abuse/Neglect/Trauma assessment.R5, R6, and R7 had the Trauma Informed Care Assessment completed on 3/13/26.Abuse policies were reviewed on 3/13/26 and no revisions were required.DON and ADON educated all staff on facility Abuse, Neglect and Exploitation policy with an emphasis on identifying abuse, reporting abuse, appropriate interventions, following resident care (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	plans, and monitoring of residents with a history of aggressive or sexual behaviors, on 3/13/26. Any staff who did not receive education will be educated prior to next shift.The DON or designee reviewed facility abuse policies and procedures with any agency staff prior to their shift.Regional Nurse Director in-serviced Administrator and DON on identifying abuse (including sexual abuse), and reporting abuse.Regional Nurse Director in-serviced Administrator and DON on process to relay information to staff regarding the resident's care plans or changes to a resident's care plans pertaining to interventions/strategies to redirect resident when exhibiting either aggressive or sexual behaviors.Emergency QAPI was held with Medical Director on 3/13/26 to discuss citation and develop interventions to ensure safety of other residents.Root Cause Analysis was completed on 3/13/26.R5, R6, and R7 had their care plan updated with safety interventions to protect from abuse.R4's care plan has been updated to reflect interventions put in place to safeguard other residents on the unit, including but not limited to: One to One supervision, providing residents with sensory items to help keep residents occupied, and hands busy.Administrator will audit weekly for 6 weeks and then monthly for 3 months to monitor residents with history of sexual behaviors, resident abuse, and if appropriate interventions are in place, and care plan updated accordingly.All Abuse findings will be reviewed by the QAPI team to ensure appropriate measures have been put in place.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect a resident's right to be free from misappropriation of resident property for two of seven residents (R9, R3) reviewed for Abuse/Misappropriation in the sample of 14. The findings include:1.R9's Face Sheet shows he was admitted to the facility on [DATE], with diagnoses including encephalopathy, cellulitis of right and left lower limbs, congestive heart failure, contracture of right and left lower extremity, restlessness and agitation, other chronic pain, low back pain, depression, and localized edema.R9's Order Summary Report dated March 16, 2026, shows an order for Oxycodone (an opioid pain medication) 5 mg (milligrams) one tablet by mouth every six hours as needed for pain, oxycodone 5 mg one tablet by mouth two times a day for pain, and oxycodone 5 mg give two tablets by mouth every six hours as needed for pain.R9's Minimum Data Set, dated [DATE], shows R9 is cognitively intact.On March 17, 2026, at 11:22 AM, R9 said he always has pain in his feet and in his buttocks. R9 said he receives pain medication. The pain medication does not get rid of the pain but does help the intensity. R9 said his pain medication was misplaced in the past.The facility's Final Report dated March 10, 2026, shows, On March 6, 2026, noted that a card containing 43 tablets oxycodone 5 mg was missing from the medication cart. The narcotic count sheet was also missing. Police notified.Following the initial report the building and all medication carts and narcotic drawers were searched, the medication was not located, no other missing items identified. Multiple attempts were made to reach the agency nurse [V19 Registered Nurse (RN)] for verbal and written statement.Video surveillance was watched by administrator. [V19 (RN)] is seen on camera remove(sic) the card from the narcotic drawer, then take the card in folded paper, place it into her personal bag, she then walks off the floor with the bag. She is seen exiting the building with her bag, placed her bag in her vehicle and return into the facility without her bag. Police department updated and video surveillance provided.On March 17, 2026, at 10:58 AM, V16 (Regional Nurse) said she was called the morning of March 6, 2026, by V2 (Director of Nursing) to report there was a card of narcotics missing. V16 said the facility tried to get a hold of V19 (RN) but could not get a hold of her. The police were called and a report was filed. V16 said that V1 (Administrator) reviewed the camera footage and saw where the theft occurred with V19. On March 17, 2026, at 12:17 PM, V1 (Administrator) said V21 (Licensed Practical Nurse) worked the morning of March 6, 2026. V1 said V21 also worked March 5, 2026. When V21 worked the morning of March 6, 2026, she noticed there was no oxycodone to give to R9. V1 said that R9 should have had another card with 48 tablets in it. V1 said that the surveillance cameras were watched and saw that V19 (RN) took the narcotic card out of the drawer and put it on top of the medication cart. V1 said V19 then turned her back to the cameras. V1 said she could see that V19 placed the card in between papers and then proceeded to place the items into her personal bag. V19 then took her bag outside of the building and put it in V19's car and then come back into the building without her bag. V1 said numerous attempts have been made to reach V19 but V19 is not returning the facility's call. V1 said the detective reached out to V19. V1 said this case will be sent to the state's attorney. The facility's Controlled Substance Administration and Accountability policy dated 2025 shows, The facility will have safeguards in place in order to prevent loss, diversion, or accidental exposure.2. R3's Face Sheet dated March 16, 2026, shows she was admitted to the facility on [DATE], with diagnoses including lack of coordination, anxiety disorder, urinary tract infection, history of falling, heart failure, and muscle weakness.R3's Minimum Data Set, dated [DATE], shows R3 is cognitively intact. The facility's Final Report dated February 23, 2026, shows, On February 10, 2026, [R3] reported to the business office manager that she only had $.17 remaining in her bank account. Bank records reflected multiple debit transactions that the resident stated she did not make. An internal investigation was conducted, including interviews with multiple staff members who provide care or services to the resident. Staff were asked if they had observed the resident's debit edit card in her room and whether (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they maintained accounts with services such as door dash (food delivery), uber (offers rides and free delivery on food), or Lyft (transportation company).On March 13, 2026, at 11:30 AM, R3 said she did not know anything was wrong until she got her bank statement and it showed she had no money. R3 said she looked everywhere for her debit card. R3 said she talked with V1 (Administrator). R3 said there were purchases over almost $200. R3 said she believed that someone from the facility took her debit card. R3 said the police came to the facility and took a report, but R3 said she has not received any updates from the facility. R3 said her debit card was in a little coin purse that was kept in her drawer. R3 said she was upset when she saw she had no money. R3 said the facility staff would take her to the store when she needed something. R3 also said she has never given anyone her card to use without her being present. R3 said her old debit card is now shut off and she has a new debit card. The facility has now given her a lock box. On March 17, 2026, at 12:17 PM, V1 (Administrator) said R3 went to the business office manager and asked her to contact the bank to find out why she did not have money in her checking out. V1 said there were several charges with door dash, uber, and Lyft. V1 said R3 did not make those charges and the police were notified. V1 said that R3 never used door dash, uber, or Lyft. V1 said the charges were all at places that were local to the facility. V1 said the local police are trying to find the address that the charges were delivered to.R3's Bank Statement shows on January 14, 2026, there were two charges for door dash from a local grocery store totaling $94.16. On January 16, 2026, there was a $7.92 charge from uber and an $.11 charge to Lyft. On January 18, 2026, there was a $7.91 charge to Lyft and a charge to door dash for $18.82 from a local restaurant. On February 6, 2026, there was a door dash charge from a local Arby's that totaled $29.71 and on February 8, 2026, a $27.72 charge for door dash from another local restaurant. These charges totaled $186.35.The facility's Abuse, Neglect, and Exploitation policy dated 2025 shows, It is the policy of this facility to provide protection for the health, welfare and right 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 mean the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of resident's belongings or money without the resident's consent. The facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written.

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement interventions to prevent a resident from developing Stage 4 pressure wounds, failed to assess the wounds in a timely manner, and failed to implement treatment interventions of the wounds for 1 of 3 residents (R1) reviewed for pressure wounds in the sample of 14. These failures resulted in R1 developing wound infections leading to sepsis.The findings include:R1's Face Sheet dated 3/17/26 shows R1 was admitted to the facility on [DATE]. R1's diagnoses include, but are not limited to, atherosclerotic heart disease, pressure ulcer of left heel, Stage 4, edema, polyneuropathy, pain in right foot, pain in left foot, hypertensive heart and chronic kidney disease, heart failure, acute kidney failure, chronic kidney disease, pressure ulcer of the right heel, Stage 4, anorexia, and abnormal weight loss.R1's care plan provided by the facility initiated on 11/3/25 shows he is at risk for impaired skin integrity due to fragile skin, bilateral lower extremity edema, reduced mobility, and the presence of an indwelling urinary catheter.R1's N Adv-Skin Check dated 11/5/25 at 2:39 PM shows he has a new, in-house acquired wound/blister of his left heel and a new, in-house acquired wound/blister of his right heel. R1's nurse practitioner (NP) documented on 11/6/25 at 1:31 AM that R1 was found to have a stage 4 right heel pressure ulcer and a stage 2 left heel ulcer in the facility. A NP note dated 11/7/25 at 12:00 AM shows R1 was being seen for bilateral foot pains and with numbness with tingling. The note shows R1 has chronic bilateral foot pains and chronic neuropathy (nerve damage causing numbness, tingling, weakness, or burning pain, often starting in the hands and feet) of his feet.R1's Wound-Weekly Observation Tools both dated 11/11/25 at 6:12 PM documented by V3, (Assistant Director of Nursing & Wound Care Nurse), show R1's right heel, stage 4 pressure ulcer was acquired on 11/11/25 and the assessment is her first observation of the wound and R1's left heel stage 2 pressure ulcer was acquired on 11/11/25 and is also her first observation of the wound. R1's Health Status Note dated 11/10/25 at 1:04 PM shows the following: Family alerted this RN (Registered Nurse) regarding wound on right heel and informing this RN family would like foam boots applied. Foam boots applied to help facilitate pressure off bilateral heels. Float heels in bed: to help facilitate pressure off bilateral heels. Wound nurse notified.R1's Physician Orders show orders written on 11/10/25 to float heels while in bed and to apply foam boots while in bed to help prevent pressure off heels. These two orders were never included in R1's care plan provided by the facility and initiated on 11/3/25.V20's (Wound Care Physician) Initial Wound Evaluation & Management Summary dated 11/11/25 of R1's wounds shows R1 has a Stage 4 pressure wound of the right heel which has been present more than one day and a Stage 2 pressure wound of the left heel which has been present more than one day. V20 removed necrotic tissue (a procedure called debridement) of the right heel wound to reveal the underlying deep tissue at the muscle/fascia level. V20's treatment plan for the right heel wound is Leptospermum honey to be applied once daily and as needed with a gauze island border dressing. R1's Physician Orders shows an order with a start date of 11/11/25 for his right heel to be cleansed with normal saline or wound wash, followed by xeroform gauze to the wound bed and covered with bordered gauze. This same wound treatment was on R1's Medication Administration Record (MAR) for November of 2025 from the dates of 11/12/15 through 11/19/25. The treatment order provided by V20 on 11/11/25 as referenced above was not placed in R1's physician orders on 11/11/25 and was not on R1's MAR or TAR (Treatment Administration Record) for November 2025.R1's Specialty Physician Wound Evaluation & Management Summary dated 11/27/25 shows his left heel wound is now unstageable necrosis. R1's Specialty Physician Wound Evaluation & Management Summary dated 1/6/26 shows R1's left heel wound is debrided and has revealed the underlying deep tissue at the muscle/fascia level, which had been obscured by necrosis previously. The wound has now revealed itself to be a Stage 4 pressure injury. R1's right heel wound is also a stage 4 pressure wound.On 3/17/26 at 1:12 PM, V20 said her recommendations for wound care treatment should be followed. V20 (continued on next page)

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	03/17/2026

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 0686 Level of Harm - Actual harm Residents Affected - Few	said if a Stage 2 pressure wound starts as a blister, the natural progression is that it hardens and becomes unstageable necrosis as it dries up. One cannot see if there is further injury underneath. V20 said she believes R1's Stage 2 left heel pressure wound was always a Stage 4 pressure wound, but she could not tell because of the overlying blister and necrosis.On 3/13/26 at 1:21 PM, V3 said she does wound rounds with V20 on Tuesday mornings and V20 will tell her of any wound treatment changes. V3 said the physician's wound notes are uploaded right into the resident's chart and she enters any new orders into the electronic medical record. V3 said new wound treatment orders should be implemented the same day they are ordered. V3 said it is obviously her fault the orders did not get put in for the right heel wound treatment as per V20's recommendations. V3 said staff inform her about any new skin alterations and she goes and does an assessment that day or the following day which includes measuring the wound, noting if there is drainage, if it is wet, and what the wound and area around the wound look like. V3 said R1 had in-house acquired pressure wounds to his right and left heels which were first identified on 11/8/25 by the floor nurse. V3 said R1's heel wounds were caused by pressure against the foot board of his bed; it was not long enough for him, and his heels were pressing against it. V3 said R1 was at risk for pressure wounds. V3 said her first formal assessment of R1's heel wounds was done on 11/11/25; it should have been done the day after they were found. V3 said after R1 acquired the pressure wounds to his heels they implemented interventions including padded booties and she thinks they put an extender on his bed.R1's Health Status Note dated 1/10/26 at 12:14 PM shows R1's family came to get the nurse because R1 did not look OK. The nurse went to assess R1 and he was jerking and responded to his name being called, but could not answer simple questions. R1's vital signs were as follows: oxygen saturation 80 percent on oxygen at 2 liters, blood pressure 130/80, temperature 103, respiratory rate 25. R1 transferred to hospital via emergency medical services.R1's After Visit Summary dated 1/22/26 from his hospital medical records printed 3/16/26 show R1 was admitted to the hospital 1/10/26 with a primary diagnosis of sepsis and discharged [DATE]. These medical records show a cardiologist consult dated 1/14/26 stating R1 presented to the ED (emergency department) 1/10/26 due to shortness of breath, confusion, fever, and rigors. R1 was admitted with sepsis secondary to urinary tract infection and wound infection. After undergoing imaging studies, R1's ulcerations to R1's right and left heels are concerning for osteomyelitis. R1's blood cultures are positive for ESBL Klebsiella (bacteria). R1 is post excisional debridement of his right and left heels down to and including muscle and bone. The podiatrist note dated 1/12/26 at 7:35 PM shows R1 has necrotic bilateral posterior plantar heel ulcers covered in necrotic, nonviable tissue which was eventually found to be the source of his sepsis. The hospitalist note dated 1/21/26 at 10:45 AM shows R1's intraoperative wound cultures from his right heel is growing vancomycin resistant Enterococcus faecalis and Proteus.The facility's Wound Treatment Management Policy (undated) shows wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change.