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	03/28/2026

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 - 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 interview and record review the facility failed to ensure a resident was free from physical abuse for 1 of 3 residents (R2) reviewed for abuse in the sample of 6. This failure resulted in R2 getting punched in the face by R3 and sustaining an abrasion and swollen lip.The findings include: R2's face sheet showed he was admitted to the facility 9/29/25 with diagnoses to include primary generalized osteoarthritis, degenerative disease of nervous system, disorientation, toxic encephalopathy, metabolic encephalopathy, mood disorder, major depressive disorder, anxiety disorder, and legal blindness. R2's facility assessment dated [DATE] showed he is severely cognitively impaired and uses a wheelchair for mobility. R3's face sheet showed he was admitted to the facility 6/3/25 with diagnoses to include dementia with behavioral disturbance, muscle wasting and atrophy, dysphagia, lack of coordination, anxiety disorder, depression, alcohol dependence with alcohol-induced persisting dementia, encephalopathy, and muscle weakness. R3's facility assessment dated [DATE] showed he has severe cognitive impairment and uses a wheelchair for mobility.R2's 12/20/25 nursing note entered at 9:55 AM showed, Resident involved in altercation in dining room at breakfast. Resident has abrasion to lower lip. No other injuries noted at this time. R2's 12/20/25 nursing note entered at 9:36 AM showed, Resident has abrasion to lower lip. Area cleansed. R2's 12/21/25 nursing note entered at 2:16 AM showed, Resident monitored closely by staff due to recent altercation with another resident. Ice pack applied to mouth area due to injury. Resident would not leave in place for very long. Small amount of red drainage noted from mouth area.R2's December 2025 eTAR (electronic Treatment Administration Record) showed a 12/22/25 order started, Monitor lower lip abrasion until healed.R3's 12/20/25 nursing note entered at 9:57 AM showed, Residents involved in altercation with another male resident in the dining room this morning at breakfast. No injuries noted at this time.On 3/28/26 at 1:10 PM, V8 CNA (Certified Nursing Assistant) said, From what I caught, the moment I saw was [R2] was at the table and [R3] was wheeling himself in. [R3] must have gotten caught on [R2's] chair because there was not enough space for him to get through. That is when the altercation started. I saw both swinging, literally throwing punches. [R2] threw a punch and [R3] threw multiple punches. there was just one injury to [R2's] lip. It was swollen and bleeding.The facility's undated policy and procedure showed, Abuse, Neglect, and Exploitation. Policy: 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. ?Physical Abuse' includes, but it not limited to hitting, slapping, punching, biting, and kicking.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement personalized fall prevention measures for a resident (R4) resulting in (R4) obtaining a laceration that required sutures, and the facility failed to prevent a resident (R1) at risk for elopement from exiting the building unsupervised. These failures apply to 2 of 3 residents reviewed for safety in the sample of 6.The findings include:1. R4's electronic face sheet printed on 3/28/26 showed R4 has diagnoses including but not limited to myasthenia gravis, disorientation, dementia without behaviors, and history of falls. R4's facility assessment dated [DATE] showed R4 has severe cognitive impairment. R4's nursing progress notes dated 2/18/26 showed, 6:30 AM Fall was not witnessed. Fall occurred in the Resident's room. Resident was attempting to self toilet at time of the fall. Reason for the fall was evident. Reason for fall: Resident stated that she tripped over fall mat located next to bed. Did an injury occur as a result of the fall: Yes. Injury details: Large unmeasurable laceration to center of forehead. L knee bruised/painful. R4's local hospital records dated 2/18/26 showed, .Presenting to the emergency department by ambulance after a fall. Patient comes from (facility) where she had a fall. Patient does not remember falling .Laceration to right forehead approximately 3cm (centimeters) .laceration repair with 9 sutures . R4's care plan dated 3/17/25 (revised 2/9/26) showed, Fall .pool noodle to left side of bed, 2/18/26 removed the floor mat from in front of her bed, and ensure her walker is within her reach at bedtime. On 3/28/26 at 2:21PM, V12 (Certified Nursing Assistant) stated, (R4's) fall prevention measures include having a mat on the floor, check on her frequently at least every 15 minutes, and offer toileting, She's had some falls, sometimes she picks the mat up and we have to put them back down again. She gets a mat to the far side of her bed by the window and another one on the other side of her bed between the bed and wall. Surveyor went to R4's room and V12 followed. V12 confirmed there was no pool noodle to the left side of R4's bed. V12 confirmed there was a fall mat on the right side of R4's bed between the bed and wall and V12 also placed a fall mat to the left side of R4's bed and placed her walker on top of the fall mat. On 3/28/26 at 2:52PM, V3 (Assistant Director of Nursing) stated, (R4's) fall prevention measures are a low bed, non-slip socks while in bed, remove fall mat in front of the bed, and keep walker within reach at bedtime. She can ambulate by herself to a point but I would rather have her have help. A fall mat would pose more of a fall risk for her because she can ambulate so we wouldn't put one on the left side of her bed. She should have never had a mat on that side of the bed. The facility's undated policy titled, Fall Prevention Program showed, Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls .7. Each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. a. Interventions will be monitored for effectiveness. b. The plan of care will be revised as needed. 2. R1's face sheet showed he was admitted to the facility 5/13/25 with diagnoses to include (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	seizures, muscle weakness, abnormalities of gait and mobility, dementia without behavioral disturbance, alcohol abuse, schizophrenia, acute kidney failure, visual disturbances, depression, and altered mental status. R1's facility assessment showed he has moderate cognitive impairment, experiences hallucinations and delusions, and ambulates with supervision or touching assistance. R1's current Physician Order Sheet showed an order started 6/19/25 for Wanderguard Left ankle – Check Placement and function. R1's Care Plan initiated 6/20/25 showed, Exit seeking/elopement risk related to cognitive impairment/Dementia. Will not leave center unattended. R1's 10/18/25 nursing note entered at 9:45 PM showed, Resident was walking quickly throughout the unit and slammed the Exit door at the nurse's station attempting to leave. Alarms were going off. I got up from the nurse's station and called out, [R1] is trying to leave. He then went to the Front door where there were 2 staff members standing there and he walked past them and eloped. I attempted to catch up to him outside but was unable to reach him. DON and another staff member got into her car and found him 6 blocks from the facility and brought him back. DON instructed me that the resident is now on 15-minute checks. I gave that instruction to the oncoming 3rd shift nurse. R1's Nurse Practitioner Follow Up note dated 10/21/25 showed, . Follow up for exit seeking, increased agitation. Patient was seen today for psychiatric evaluation. Resident reported he had episode of increased hallucinations of ghosts which were very disturbing causing patient to exit the building. Patient agreed to return to the facility and has been closely monitored by staff since the incident. On 3/28/26 at 9:55 AM, V4 RN (Registered Nurse) said, It was around 10 pm, I was waiting for 3rd shift, sitting at the desk. [R1] walked past, went to the exit across from the nurse's station, and he started banging on the doors with a lot of force. Trying to bang down the door. The alarm started going off, so he ran in another direction looking for another door. I ran down the hall with him and I screamed to another lady that [R1] was trying to escape, they just let him out the door. I don't remember how far he actually got. a staff member [V9- CNA (Certified Nursing Assistant] got in a car with someone else to try and find him. They did find him. I had gotten in my car and went in the opposite direction. He didn't say anything about where he wanted to go or what he was doing, he just came and banged on the doors. On 3/28/26 at 11:30 AM, V9 CNA (Certified Nursing Assistant) said, It was about 9:45 PM that day when [R1] left. Normally when [R1] leaves his room and goes for a walk around the building, we back off and leave him alone. He walks off his aggression. That night in particular, I was coming off the back hall and he stormed down the center hallway, toward the front door. He banged on the front door until it opened, and he went out the front door. The nurse on duty was [V4]. She went after him, and I went after him with the previous Director of Nursing (V10) driving me. There was another nurse coming in the building at the time and he got out of the building and by the time we were able to get in the car and go follow him, he was 3 blocks down, past the funeral home parking lot on the sidewalk. He wanted to go home. It was raining. I got out of the car, and I walked with him for a while, because the sidewalk was busted up and I didn't want him to trip and bust his head up on the cement. We got him into the car and brought him back. We got back to the building about 10:30 that night. He went out at about 9:45 PM. I saw him walking because I knew what he looked like, since I had worked with him before. He had done this before. He has periods of agitation, because of his psychiatric issues and he will get agitated and when he walks around the building, he is either agitated or bored. I normally back (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	off and leave him alone. don't remember when he got out the first time, that was when they put the wander guard on him. he didn't have the mental capability of signing himself out. He was walking by himself when I saw him. He was wearing shorts, tennis shoes, and a gray hooded sweatshirt. On 3/28/26 at 3:01 PM, V1 Administrator said, I was not in the building when it happened. I got a call that he had been pacing around in the facility and that he had gone out through the front door. they did tell me they were able to stay with him and talk him into coming back in. I was then able to go in and view the camera footage and I was able to see that he did go to the front door. He pushed on the door, and it didn't open right away because of the wanderguard. He then went out the front door and was in the parking lot . it was not originally reported that way to me ever. (R1 leaving unsupervised, staff leaving in cars to find him, and being picked up by car.) . I watched him on camera footage. Staff was never not with him on camera. I don't have that footage. Our cameras only store footage for 7 days. The facility's undated policy and procedure showed, Elopements and Wandering Residents. Policy: This facility ensure that residents who exhibit wandering behavior and/or at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. Definitions: 'Elopement' occurs when a resident leaves the premises or a safe area without authorization. and/or any necessary supervision to do so. Adequate supervision will be provided to help prevent accidents or elopements.