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	04/10/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure medications were administered on time and medications were administered under the supervision of the nurse for 1 of 5 residents (R8) reviewed for medication administration in the sample of 9.The findings include: On 4/10/26 at 9:58 AM, V11, Licensed Practical Nurse (LPN), said she is giving R8 her 7:00 AM and 8:00 AM medications. V11 said it's not because she is late, it's because she has 13 (resident) blood sugars (glucose) to check.On 4/10/26 at 10:35 AM, R8 said she has not gotten her pills, her nasal spray, her eye drops, or her inhalers yet today.On 4/10/26 at 11:04 AM, V11 returned to R8's room with a med cup full of pills. R8 dumped the medications into her pudding and swallowed them, then her nasal spray was administered followed by her inhaler. No eye drops were observed being given.On 4/10/26 at 11:07 AM, a white patch dated 4/10 and initialed (indecipherable) with the backing still intact was on R8's overbed table. V11 said the pain patch is supposed to be put on in the morning at 6:00 AM.On 4/10/26 at 10:16 AM, R8 said she usually gets her medications late; somewhere between 10:30 AM and 11:30 AM.On 4/10/26 at 10:27 AM, R8 said she can get her morning medications anywhere from 6:30 AM and 10:30 AM. R9 said the nurse gives her a cup of her medications and she keeps them with her and takes them at 9:30 AM. R9 said the nurse does not watch as she takes them.R8's Medication Administration Record (MAR) for 4/1/26 to 4/30/26 shows an order for a pain-relieving external gel 3.5 percent (%) (Menthol topical analgesic) to be applied to the left arm twice a day as needed for pain. None of the patches are signed out as being administered for the month of April 2026 on R8's MAR. No other topical patches are on R1's MAR.On 4/10/26 at 11:58 AM, V13, Registered Nurse (RN), said medications are considered on time if they are given one hour before and one hour after they are scheduled.On 4/10/26 at 12:33 PM, V2, Director of Nursing (DON), said medications can be given an hour before and an hour after the scheduled time and still be considered on time.On 4/10/26 at 1:40 PM, V10, Regional Director of Operations, said the nurse should watch as the medication is taken and should apply any topical medications. Medications should not be left with the patient to take or apply by themself.R8's Medication Admin. Audit Report dated 4/10/26 shows R8 has orders to receive the following medications at 8:00 AM each morning: docusate sodium, lactobacillus, B-Complex with biotin and folic acid, fluticasone propionate nasal spray, budesonide-Formoterol fumarate inhaler, ezetimibe, black cohosh, calcium, cetirizine, cranberry, Lasix, Gabapentin, glucosamine, sertraline HCL, polyvinyl alcohol eye drops, magnesium oxide, artificial tears, gabapentin, spironolactone, potassium chloride ER, midodrine, multivitamin with minerals, topiramate, propranolol, cholecalciferol, and fiber. R8's Medication Admin Audit Report dated 4/10/26 shows V11 administered the above ordered medications anywhere between 9:30 AM and 1:56 PM on 4/10/26.The facility's Medication Administration Policy (not dated) shows the six rights of medication are followed: right resident, right drug, right dosage, right route, right time, right documentation. Administer within 60 minutes prior to or after scheduled time. Observe resident consumption of medication.

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview, and record review, the facility failed to administer insulin on time, failed to administer the correct insulin dose, and failed to administer a cardiac medication to 2 of 4 residents (R4 and R8) reviewed for medication administration in the sample of 9.The findings include:1.On 4/10/26 at 9:58 AM, V11, Licensed Practical Nurse (LPN) said she is giving R8 her 7:00 AM and 8:00 AM medications. V11 said it's not because she is late, it's because she has 13 (resident) blood sugars (glucose) to check. V11 said R8 has Humalog (a fast-acting insulin) per sliding scale and also has 70 units (of another insulin) scheduled. R8 was observed as she attempted to scan her glucose sensor with her phone. R8 said it didn't work. R8 said she already ate her breakfast. V11 said she will have to check R8's glucose with a finger stick and proceeded to do so. The result shows 326. V11 said she usually doesn't have to worry about checking R8's blood sugar with breakfast because she usually scans her sensor.On 4/10/26 at 10:14 AM, V11 returned to R8's room to give her insulin. V11 showed the medication, and it was a Tresiba pen (ultra long-acting insulin) set to 70 units. V11 administered 70 units of the Tresiba insulin subcutaneously to R8's abdomen. V11 said she saw that R8 already got 5 units scheduled before breakfast.On 4/10/26 at 10:20, V11 said she will be giving Humalog 38 units since her glucose was 365. V11 said if it's (the glucose) above 331, the order is for 38 units. V11 showed the Humalog pen which was dialed to 32 units. V11 said that's all that's left. V11 administered the Humalog 32 units to R8's abdomen, then she left to obtain a new pen for the necessary additional units.On 4/10/26 at 10:41 AM, V11 returned with the new Humalog Kwik pen which she dialed to 4 units for R8. After discussing the order parameters for the sliding scale insulin, V11 said she wrote down R8's glucose at 365. Per surveyor's observation, it was 326. V11 consulted R8's MAR (medication administration record) and no value was recorded. V11 said she didn't save it, then V11 said, thank you for stopping me.On 4/10/26 at 10:47 AM, V11 asked R8 if she wrote it (the glucose result) down. R8 said she didn't write it down, but it was three twenty something. V11 said if she gave the Humalog 4 units, that would have been a medication error. V11 said R8 already got the correct amount of Humalog if her glucose was 326. R8's Medication Admin Audit Report dated 4/10/26 showed an order for Humalog 100 units per milliliter (ml) 5 units to be injected subcutaneously before meals scheduled at 7:00 AM and Humalog KwikPen Subcutaneous solution pen injector 100 unit/ml inject subcutaneously per sliding scale at 7:00 AM before meals as follows: if glucose is 301-330 = 34 units, if greater than 331 give 38 units. R8's Medication Admin Audit Report dated 4/10/26 shows an order for Tresiba FlexTouch subcutaneous solution pen injector 200 unit/ml inject 56 units subcutaneously in the morning scheduled at 8:00 AM. R8's Medication Admin Audit Report dated 4/10/26 shows Humalog 5 units was administered on 4/10/26 at 10:56 AM and Tresiba 56 units (although it was witnessed as above to be 70 units) was administered at 11:16 AM on 4/10/26. R8's Medication Administration Record (MAR) for 4/1/26 through 4/30/26 shows V11 administered R8's Humalog 34 units (although it was witnessed as above to be 32 units) and R8's Medication Admin Audit Report dated 4/10/26 shows it was administered at 10:55 AM on 4/10/26.On 4/10/26 at 11:58 AM, V13, Registered Nurse (RN), said medications are considered on time if they are given one hour before and one hour after they are scheduled. V13 said sliding scale insulin needs to be given about one hour prior to meals.On 4/10/26 at 12:33 PM, V2, Director of Nursing (DON), said medications can be given an hour before and an hour after the scheduled time and still be considered on time. V2 said insulin, including sliding scale insulin, should be given 15 to 30 minutes prior to a meal, so the resident's blood sugar (glucose) doesn't drop.2.R4's MAR for 3/1/26 through 3/31/26 shows an order written on 3/17/26 at 11:00 PM for Dofetilide 50 micrograms (mcg) to be given by mouth twice a day (8:00 AM and 8:00 PM) for atrial fibrillation (an abnormal heart rhythm). The same MAR shows a 9 for the 8:00 AM dose on 3/18/26. The chart codes on the same MAR show a 9 means Other / See Progress Notes Effective. R4's Progress Notes dated 3/18/26 at 9:01 AM show dofetilide oral capsule 250 mcg give 250 mcg by mouth two times a day for atrial fibrillation is not available.On (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/10/26 at 12:26 PM, V2, Director of Nursing (DON), said, there should be a nursing note if family had been asked to bring medications for a resident from home. V2 said they do not have dofetilide available from their pharmacy, it is not on their formulary, and they do not keep it in their facility. On 4/10/26 at 12:33 PM, V2 said it is the facility's responsibility to make sure residents have their medications.On 4/10/26 at 2:55 PM, V1, Administrator, said if they don't have a medication available, they need to contact the doctor and inform them, and follow the doctor's orders. V1 said the nurse should not just document not available and not give it.The facility's Timely Administration of Insulin Policy (not dated) shows it is the policy of this facility to provide timely administration of insulin in order to meet the needs of each resident and to prevent adverse effects on a resident's condition. All insulin will be administered in accordance with physician's orders. Insulin administration will be coordinated with meal times. Before administering insulin, perform two nurse verification of correct resident, dose calculations, and correct route of administration. Administer insulin at appropriate times.The facility's Medication Administration Policy (not dated) shows the six rights of medication are followed: right resident, right drug, right dosage, right route, right time, right documentation. Administer within 60 minutes prior to or after scheduled time. Observe resident consumption of medication.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a resident room was sanitary for 1 of 4 residents (R4) reviewed for environment in the sample of 9.The findings include:On 4/10/26 at 12:07 PM, resident room [ROOM NUMBER] B had a wall mounted heating/cooling unit under the window. Underneath the unit, along the baseboard there was a section of the drywall that was bumpy and black in color. On 4/10/26 at 12:11 PM. V8 Maintenance, with this surveyor, observed the area in room [ROOM NUMBER] B. V8 said that it was not black mold but was a buildup of dirt and debris from the condensation gathering there from the heating/cooling unit. V8 said moisture sits there and erodes the drywall and the dirt and debris collects there. V8 said the drywall needs to be fixed in that area, it should not be black. R4's Census shows that R4 resided in room [ROOM NUMBER]B during her stay at the facility.The facility's Routine Cleaning and Disinfection Policy dated 2025 shows It is the policy of the facility to ensure the provision of routing cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible.