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	06/01/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to document the reason for a transfer to the hospital for 1 of 3 residents (R1) reviewed for hospitalization in the sample of 13.The findings include:R1s face sheet shows she was admitted to the facility on [DATE]. The same document shows she was discharged on 4/19/26. The nursing progress notes of 4/19/26 do not show the transfer/discharge, why she was discharged , where she was discharged to, and no bed hold issued.On 5/30/26 at 12:22 PM, V6 Registered nurse said when a resident is sent to the hospital, they are given paperwork including, the face sheet, any notes that would be relevant to the transfer, any interventions done prior to the transfer, and an assessment. A note would be put in the record showing who was notified and what was all done. It would be important so other staff can see the information of what took place.On 5/30/26 at 12:30 PM, V2 Director of Nursing stated when a resident is sent out to the hospital for any reason the paperwork sent with them should include the face sheet, POLST (Physician orders for Life-Sustaining Treatment), and a copy of the bed hold. There should be an order from the physician or Nurse Practitioner why they are being sent. There should be a progress note entered stating the condition of the resident and reason for the transfer, any interventions attempted at the facility and family notifications. V2 said R1s family came in were upset about her wound. They called 911 themselves and had her sent out. She believes the nurse gathered the paperwork to send with her to the hospital, but it should have been documented in the notes. She had received a call on 4/19/26 from V10 Licensed Practical Nurse LPN telling her about the situation. Upon review of R1s record, V2 said V10 did not make any progress notes regarding the transfer. V2 said she would expect documentation since the facility did not initiate the transfer.On 5/30/26, this surveyor attempted to contact V10 and was unable to leave any message.The facility's undated policy for Transfer and Discharge documents: 10. Emergency Transfers to Acute Care. A. The facility will obtain a physician's order for emergency transfer or discharge, stating the reason the transfer or discharge is necessary on an emergency basis. F. Document assessment findings and other relevant information regarding the transfer in the medical record. G. provide a notice of transfer and the facility's bed hold notice policy to the resident and representative as indicated.

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 0686 Level of Harm - Minimal harm or potential for 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 observation, interview and record review the facility failed to perform weekly assessments for a pressure injury, failed to have an ordered pressure injury treatment in place, and failed to have preventive interventions in place for 3 of 3 residents (R1, R3, R4) reviewed for pressure injuries in the sample of 13.The findings include: 1. R1s face sheet documents she was admitted to the facility on [DATE] with multiple diagnoses including but not limited to Parkinson's disease, hypertension, and altered mental status. R1s progress note of 1/7/26 documents an open area noted to the sacrum measuring 1 cm by 1 cm (length by width in centimeters). The area cleansed with normal saline, applied xeroform and padded adhesive once daily and (as needed). The progress notes and assessments were reviewed and show no further assessment of the wound. No weekly assessments were noted. On 3/7/26, V5 (former Assistant Director of Nursing) documented she was notified R1 had an open area to her sacrum. The area measured 2 cm by 2 cm. The wound doctor was notified and placed on rounds for the wound nurse. R1s initial wound evaluation and management summary of 3/10/26 documents an unstageable pressure wound to the sacrum. The wound measured 2.2 cm by 3.2 cm with light drainage. On 5/30/26 at 12:22 PM, V6 Registered Nurse said when a new skin issue is identified the wound is cleaned and dressing put in place. The wound doctor needs to be notified and the family. The documentation would include what, where the wound was located, and should include measurement. The wound doctor does the weekly assessments. On 5/30/26 at 12:30 PM, V2 Director of Nursing said the nurses should be documenting measurements when an open area is identified. There should be a description of the wound, and orders put in place, and the wound nurse and physician notified. Once a wound is identified there should be weekly assessments to monitor the wound for any improvements, decline or signs of infection. V2 said she looked through the record and did not see where R1s wound had weekly wound assessments following the wound from 1/7/26. The facility undated policy for pressure injury prevention and management documents a pressure injury refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence. 3. Assessment of pressure injury risk c. Licensed nurses will conduct a full body skin assessment on all residents upon admission/re-admission, weekly, and after any newly identified pressure injury. Findings will be documented in the medical record. Findings should include type of wound, wound measurements,(measured upon discovery and at least weekly thereafter), other wound characteristics (color, exudate, odor, pain, tissue type in wound bed), and treatment and interventions implements. 2. On 5/30/26 at 9:48 AM R3 was on her back in bed with her heels laying on the mattress not being offloaded. R3's heel boots were on the couch in her room. At 9:51 AM, V16 Assistant Director of Nursing went into R3's room with the surveyor for a skin check on her heels. R3 had a (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	purple/burgundy area to her right and left heel. V16 stated the heel boots should be in place for R3 to prevent more injury to her heels. On 5/30/26 at 10:49 AM V3 Assistant Director of Nursing/Wound Nurse stated the wound to R3's heel was identified during wound rounds with the wound doctor last Wednesday. V3 stated R3 has a deep tissue injury. Skin prep and floating the heels were the preventative measure and treatment. V3 stated the offloading boots were provided. On 5/30/26 at10:57 AM, V3 went to R3's room with the surveyor to check her coccyx wound. There was dry dressing in place that was not dated. V3 removed the dressing and the large open wound to R3's coccyx did not have any packing inside. There was some serosanguinous drainage and mild odor present. V3 stated there should have been a medicated soaked gauze to the wound. V19 Certified Nursing Assistant was present and stated the hospice nurse was there and did the dressing that morning. On 5/30/26 at 1:28 PM, V17 Corporate Nurse stated they followed up with the hospice nurse who stated she just put a dry dressing over R3's coccyx wound. The hospice nurse did not put the correct dressing in place. The wound care provider's Wound Evaluation & Management Summary dated 5/27/26 for R3 showed end stage skin failure to the right and left heel. The approach that was recommended was off-loading and skin prep daily to the heels. End stage skin failure of the sacrum – full thickness; 13 cm x 24 cm x 0.9 cm with 5.6 cm of undermining at 10:00 o'clock. The dressing treatment plan: sodium hypochlorite solution, apply once daily as needed. Twenty -five percent solution to moisten 4.5-inch gauze roll daily. Moisten with the solution and then pack into the wound. Dry dressing as a secondary dressing daily. May 2026 Physician Orders for R3 showed apply heel boots at all times when in bed or float heel to relieve pressure if heel boots are not available. Pressure wound to sacrum: cleanse with normal saline, apply sodium hypochlorite solution-soaked gauze to wound bed, do not over pack, cover with dry dressing once daily and as needed if it becomes saturated, soiled or dislodged. The March 23, 2026 Minimum Data Set for R3 showed she was dependent for all activities of daily living. The Care Plan dated 3/27/26 for R3 showed she was admitted and returned from the hospital with a stage 4 sacral pressure ulcer. Treatments as ordered. The facility's Pressure Injury Prevention and management policy (2026) showed evidenced based interventions for prevention will be implemented for all residents who are assessed at risk or who have pressure injury present. Basic or routine interventions could include, but are not limited to redistribute pressure.offloading heels, etc. The facility's Wound Treatment Management policy (2025) showed, wound treatments will be provided in accordance with physician orders, including cleansing method, type of dressing, and frequency of dressing change. 3. On 5/30/26 at 9:59 AM, R4 was asleep in his chair next to his bed. R4 had grip socks on with athletic shoes on over the socks. R4 had a cast shoe sitting on the bed. V16 Assistant Director of (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing was with the surveyor for a skin check of his right heel that she stated she thought was healed. V16 noted some swelling to R4's lower legs. V14 Registered Nurse came into the room and stated R4 has a deep tissue injury to his right heel that they are putting skin prep on. R4 was awake and stated he was told that the area was healed. V14 removed the sock and shoes to his right foot and there was black necrotic tissue present. V14 stated they put his shoes on when he goes to meals and then when he comes back to his room, they switch his right shoe to the cast shoe when he is sitting in the chair. V16 noted swelling to his feet and lower legs. V14 then re-applied R4's shoes and was having difficulty getting the shoes over his heels. R4 complained of pain to his feet and heels at that time. V16 told V14 that R4 should have the cast shoe on. V4 agreed to wear it and stated he had that at the hospital because of his right heel. On 5/30/26 at 10:49 AM V3 Assistant Director of Nursing/Wound Care Nurse stated R4 should have his heels floated when he is in bed or a heel boot in place. V3 stated staff should remind R4 to wear the walking shoe. The wound care provider's Initial Wound Evaluation & Management Summary for R4 dated 5/27/26 showed an unstageable due to necrosis, full thickness wound of his right heel. The wound was present upon admission. Skin prep to the heel and off loading of the wound was recommended. The Face Sheet dated 5/30/26 for R4 showed diagnoses including unstageable pressure ulcer of the right heel, sepsis, acute cystitis with hematuria, chronic kidney disease, muscle wasting and atrophy, protein-calorie malnutrition, and acute respiratory failure with hypoxia. The Care Plan dated 5/26/26 for R4 showed impairment of skin integrity to the heel. Keep the skin clean and dry. Weekly treatment documentation. There were no interventions for preventative measures that would include off-loading of the heel. The facility's Pressure Injury Prevention and management policy (2026) showed evidenced based interventions for prevention will be implemented for all residents who are assessed at risk or who have pressure injury present. Basic or routine interventions could include, but are not limited to redistribute pressure.offloading heels, etc.