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	06/05/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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 interviews and record review, the facility failed to adequately supervise a known wandering resident (R1) who was evaluated to be at risk for elopement, failed to remain with an eloped resident (R1) once found out in the community, and failed to assure a secured door was locked preventing access to a wandering resident (R1). These failures resulted in R1, a moderately cognitively impaired resident with the diagnosis of unspecified dementia, eloping from the facility through the Maintenance Office exterior exit door, crossing a moderately busy road to a gas station and park approximately one block from the facility. These failures have the potential to affect all three (R2, R3, R4) Elopement Risk residents who reside off the secured floor in the facility.The Immediate Jeopardy began on April 14, 2026, when R1 eloped from the facility. V1 (Administrator) was notified of the Immediate Jeopardy on June 5, 2026, at 9:52 AM. The surveyor confirmed by interview and record review that the Immediate Jeopardy was removed, and the deficient practice corrected, as of April 15, 2026, prior to the start of the survey on June 2, 2026, and was therefore Past Noncompliance. This past non-compliance occurred from April 14, 2026 -April 15, 2026.Findings include:The facility's policy, Elopement and Wandering Residents, not dated, documents not in its entirety, This facility ensures that residents who exhibit wandering behavior and/or are 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: Wandering" is random or repetitive locomotion that may be goal-directed {e.g. the person appears to be searching for something such as an exit), or non-goal directed or aimless. Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e. an order for discharge or leave of absence) and/or any necessary supervision to do so. Policy Explanation and Compliance Guidelines:1. The facility is equipped with door locks/alarms to help avoid elopements. 2. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner. 3. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. 4. Monitoring and Managing Residents at Risk for Elopement or Unsafe Wandering a. Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team, b. The interdisciplinary team will evaluate the unique factors contributing to risk in order to develop a person-centered care plan, c. Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff, d. Adequate supervision will be provided to help prevent accidents or elopements, e. Charge nurses and unit managers will monitor the implementation of interventions, response to interventions, and document accordingly, f. The effectiveness of interventions will be evaluated, and changes will be made as needed. Any changes or new interventions will be communicated to relevant staff.The Final Abuse Investigation Report sent to (the (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	State Agency) dated 4/15/26, documents, on 4/14/26, It was noted at approximately 3:42 pm that (R1) was at the park near the nursing home, eating some tacos and watching kids play ball. He was immediately brought back by staff. A head-to-toe assessment was completed upon return by the nurse (V5/Licensed Practical Nurse), and no injuries were noted. Staff verified his wander guard was in place and functioning properly. (R1) became agitated and attempted to remove his wander guard bracelet. (R1) was placed on a 1:1 (one-to-one) with our Activity Director. This is not normal behavior for him, so he was sent out for examination due to his behavior, to clarify if there was an acute medical condition to cause his behavior. While in the hospital his medications had some adjustment made. Upon review of the camera footage, you can see (R1) pacing outside the breakroom looking for a pop, when he noticed the open door and he was able leave the facility via the maintenance exit. The maintenance door did not fully close when staff exited the office and (R1) was able to enter their office and go out the exterior door from their office which is why the wander guard system did not alarm. Maintenance staff were immediately educated on keeping their door ALWAYS closed and locked for resident safety reasons. Upon further inspection, it was noted that the door closure was not functioning properly, Maintenance immediately brought a new closure for the door and installed it on 4/14/26, the door is now fully functioning, and it remains locked at all times. (R1) was moved to our locked memory care unit and the dashboard is updated for staff to offer the (R1) a pop if he is pacing or agitated, because that is typically what he is looking for.R1's admission record documents R1's date of admission to the facility was 5/14/25 and his diagnoses included but are not limited to: Other Seizures, Unspecified Dementia/Unspecified Severity, without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, or Anxiety, Alcohol Abuse, Uncomplicated, Schizophrenia, Unspecified, and Anxiety Disorder, Unspecified.R1's Minimum Data Set (MDS) assessment, dated 4/1/26, documents R1 has a Brief Interview for Mental Status (BIMS) score of 10/15, indicating moderate cognitive impairment, documents R1 has non-Alzheimer's dementia and documents R1's ambulation for distances over 10 feet as supervision or touching assistance.R1's physician orders dated 4/16/26, documents R1 has an order for a Wander-guard to check placement and function every night shift for monitoring.R1's current care plan documents R1 is Exit seeking/elopement risk related to cognitive impairment/Dementia and (R1) may wander and look for soda-pop and staff will assist him to obtain.R1's elopement risk assessment dated [DATE], documents R1 is an elopement risk with a score of one (1), and elopement risk assessment dated [DATE] documents an elopement risk with a score of three (3).On 6/3/26 at 12:48pm V1 (Administrator) provided a screenshot picture of the facility's surveillance video which showed R1 leaving the building unsupervised through an open door at the back of the building. The picture of the video surveillance was timed stamped at 15:25 (3:25pm) on 4/14/26.On 6/2/26 at 9:15am, V4 (Regional Director of Operations) stated that on 4/14/26 video surveillance showed R1 opened the maintenance office door that was not securely locked and exited the building through an exterior door within the office.On 6/2/26 at 10:00am, V16 (Maintenance Director) stated, The door closure to the office (Maintenance) wasn't automatically closing like it should, it would stop which prevented the door from latching all the way and locking. I was told he (R1) came through the door and left the building through here by V4 (Regional Director of Operations) and was asked to come look at the door, so that's when I noticed it wasn't working. I called V17 (Maintenance Assistant), and he came in and helped me replace it that night.On 6/2/26 at 2:52pm, V5 (Licensed Practical Nurse/LPN) stated she was R1's nurse on 4/14/26 when he left the building and was found at the park. V5 stated R1 had been doing his normal walking like he always does and was not acting any different than normal. V5 stated she was unaware that R1 had left the building unsupervised until V6 (Certified Nursing Assistant/CNA) came back from her lunch and asked if V5 was aware that R1 was at the park. V5 stated that V6 did not stay at the park with R1.On 6/2/26 at 3:08pm, V6 (Certified Nursing Assistant/CNA) stated she was returning to work on 4/14/26 from break when she drove by the park and noticed a man who looked like (R1) walking with another person on the sidewalk next to the park. V6 looked back in her rearview mirror and verified that it was (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(R1) who was now alone. V2 immediately stopped her car and yelled his (R1) name and (R1) came over to V6. V6 attempted to get R1 to come back to the facility with her but he was getting agitated, so she backed off, called the facility, asked them if they knew (R1) was at the park and I was told that they were not aware. V6 got back into her car, leaving R1 alone at the park and drove back to the facility.On 6/3/26 at 8:44am, V7 (Certified Nursing Assistant/CNA) stated that she was working on 4/14/26 when R1 was found at the park. V7 stated that V6 (Certified Nursing Assistant/CNA) called her asking if she (V7) knew R1 was at the park and V7 stated she did not know. V7 stated she and V1 (Administrator) went to the park where R1 was alone and was able to bring him back to the facility. V7 also stated she had seen him (R1) earlier in the day sitting in the chair in his room and he had asked for a pop, I didn't know he had left his room.On 6/3/26 at 9:12am, V10 (Certified Nursing Assistant/CNA) stated that she was working on 4/14/26 when R1 got out of the building unsupervised. V10 stated that she and V17 (Speech Therapist) saw R1 walk toward the therapy gym and turn right into the small hallway that led to an exterior door. V17 walked down to see what R1 was doing and asked R1 what he was looking for and R1 told her he wanted a pop so V17 pointed down the hallway to show R1 where to go to get a pop. V10 stated she did not see R1 the rest of the day that she could recall.On 6/3/26 at 10:01am, V17 (Speech Therapist) stated she was working on 4/14/26 when R1 exited the building. V17 stated she watched R1 walk down the hallway toward the therapy gym and turn right into the hallway next to the therapy gym, so she asked if he needed anything and R1 told her he wanted a pop. V17 stated, I walked him up the hallway and pointed toward the breakroom and told him that is where he could get a pop. Within the next hour I think I heard he got out of the building.On 6/3/26 at 11:00am, R1 stated, I had a premonition that day and wanted to see my friends, I was upset because I felt like this place (facility) was a prison. R1 stated he does not recall how he left the building or how long he was gone but stated, I use to leave my sister's house and forget where I was or where I was going so, they put me here to keep me safe. I don't remember too good, and I hear and see things sometimes. They moved me to this room so I can be safe and I'm ok with that because I don't want them to worry about me.On 6/3/26 at 11:15am, V23 (Regional Nursing Consultant) stated that it is the expectation if staff find a resident that has eloped from the facility that the staff member remain with the resident for their safety if unable to get them to return to the facility until additional help can arrive to assist.Prior to the survey date of 6/2/2026, the facility had taken the following actions to correct the non-compliance:1. Immediate actions taken: R1 has an (electronic wander device) in place and is fully functioning on 4/14/26; R1 had a head-to-toe assessment, no concerns identified on 4/14/26; R1 was sent to the ER (Emergency Room) and admitted to the hospital on [DATE] and returned to the facility on 4/16/26 to avroom and was placed on 1:1 (one-to-one) supervision at that time; R1 was moved to the secure Memory Care Unit, on 4/17/26 and the 1:1 was discontinued at that time; Education with maintenance staff on keeping the office door locked was conducted on 4/14/26; Door closure has been replaced on 4/14/26, to ensure the automatic door closure/lock is fully functioning. All other doors were assessed and were fully functional.2. All residents have the potential to be affected; no others were identified at this time.3. Measures put into place/systems changed: An in-service was initiated by the RDO (Regional Director of Operations/V4) with maintenance staff on 4/14/26 that includes: 1) Keeping the maintenance door locked at all times. 2) the alleged deficiency; An in-service was initiated by the Administrator (V1) to all staff on 4/15/26 that includes: 1) Elopement Protocol. 2) Abuse, Neglect, and Exploitation Policies. 3) The alleged deficiency; Maintenance Director or designee will conduct a QA (Quality Assurance) study to determine 1) was the maintenance door locked and secured? The results of this tool will be reviewed during the facilities Quality Assurance Performance Improvement meetings. Any issues identified will be immediately corrected. This QA study will be performed 5 (five) times per week for a period of 2 (two) months. Administrator will monitor overall compliance; Administrator or designee will conduct an audit to determine if any elopements have occurred and if so, did staff follow policy. This QA (Quality Assurance) study will be performed once per week for a period of 90 days to ensure that all staff follow the elopement policy and procedure.