| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145027 | A. Building<br>B. Wing | 06/17/2026 |

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| Allure of the Quad Cities | 833 Sixteenth Avenue<br>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) |
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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to identify an area of pressure for a resident at risk of developing pressure injuries, failed to do a full assessment of the wound when it was identified, and failed to obtain a treatment order when it was first identified for 1 of 3 residents (R2) reviewed for pressure in the sample of 11. These failures caused the wound to further deteriorate and become necrotic (non-viable, dead skin tissue).The findings include:R2's admission Record, provided by the facility on 6/17/26, showed he had diagnoses including, but not limited to a fracture of lower end of right tibia, anemia, type II diabetes mellitus, hypertension, unspecified fracture of sacrum, unspecified protein-calorie malnutrition, non-pressure chronic ulcer of other part of right foot, pain in right leg, abnormal gait and mobility, unspecified fracture of unspecified lumbar vertebra, procedure and treatment not carried out because of patient's decision for unspecified reasons, and patient's noncompliance with other medical treatment and regimen due to unspecified reasons. The admission record showed R2 was admitted to the facility on [DATE], The admission record showed a diagnosis for an unstageable pressure ulcer to his right heel with an onset date of 4/2/25. R2's 3/13/25 facility assessment showed he was cognitively intact. The assessment showed R2 was dependent on staff for bed mobility and transfers. The assessment showed R2 did not have any pressure ulcers on admission, however, he was at risk for developing pressure injuries.R2's care plan initiated 3/7/25, showed he had an ADL (activities of daily living) self-care deficit related to physical limitations and was non-weight bearing for 3 months.R2's Care plan initiated 3/7/25 showed he was at risk for alteration in skin integrity related to diabetes and recent surgery. The care plan showed staff should encourage to reposition as needed, use assistive devices as needed, observe skin condition with ADL care daily, report abnormalities.R2's Care plan initiated 3/14/25, showed Resistive/noncompliant with treatment/care related to refusing evening medications. The care plan showed staff should allow for flexibility in ADL routine to accommodate mood, preferences, and customary routine.R2's notes from a local hospital, printed on 3/6/25 (the day he was admitted to the facility), did not identify any pressure wounds for R2 when he was discharged from the hospital to the facility.R2's Type: N ADV Clinical admission dated 3/6/25 showed he arrived at the facility via ambulance on a stretcher, was alert and oriented, pleasant with no unwanted behaviors. The assessment showed skin issues to his right dorsum second digit (second toe) and his right knee surgical incision. Effective Date: 03/09/2025 Type: Health Status Note showed Resident alert and cooperative with cares this shift. R2's progress notes from 3/6/25 through 3/31/25 were reviewed showing R2 refusing lab draws and some of his medications. No refusals of repositioning or offloading were documented in R2's progress notes from 3/6/25-3/31/25. The only place documentation regarding procedure and treatment not carried out because of patient's decision for unspecified reasons, or patient's noncompliance with other medical treatment and regimen due to unspecified reasons (other than some lab draws or some medications) from 3/6/25 through 3/31/25 progress notes was under V22 and V23's (Nurse Practitioners) progress notes under R2's past medical history notes, and in R2's diagnoses upon admission.R2's 3/27/2025 Type: N Adv - Lift/Transfer Evaluation showed resident is non-weight bearing, is cooperative with transfers, cooperative with repositioning and is partially able to assist<br>(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 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | with repositioning in bed and chair.On 6/16/26 at 10:35 AM, R2 said he went to the facility for therapy after he fractured his right femur. R2 said he would refuse some of the medications at the facility because he felt they had him on a lot of medications he did not need. R2 said he would not refuse any care, adding, That is what I was there for was to receive care and get better so I could go back home. R2 said while he was in the facility, he developed pressure sores. R2 said he could reposition himself some in bed, but he needed two staff to assist him with toileting and transfer needs.R2's 3/31/25 Type: N Adv - Skin Check showed a new skin issue: Right lateral foot. Heel pressure injury measuring 2.5 centimeters (cm)in length x 1.4 cm width, by 0 depth. No further description or characteristics of the wound bed were documented in the assessment.R2's 3/31/25 progress notes did not document a new skin issue/pressure injury to R2's right heel or document a full assessment.R2's Skin/Wound Note dated 4/2/25 showed Resident was seen on 3/26/25 by V15 (Wound Doctor contracted through facility). Please refer to wound notes. The note was written by V21 (previous Assistant Director of Nursing-ADON)V15's wound notes dated 3/12/25 showed Signing off on patient who remains in the facility. Sign off without visiting. In house.On 6/16/26 at 2:25 PM, V15 said on 3/12/25 she signed off on R2. V15 said she was told she did not need to see him. V15 said it would either be because he did not have any wounds, or he did not need to be seen by her. V15 said the facility did not refer R2 to her for the pressure wound to his right heel until 4/2/25. V15 said someone should have seen it before it became necrotic tissue. V15 said R2 had dark skin so staff may not have noticed it. V15 said R2 had limited mobility, and arthritis everywhere. V15 said she has followed R2 throughout several facilities. V15 said the 4/2/25 assessment was the initial presenting wound to R2's right heel. V15 said R2's capability for healing is very low. He has decreased blood flow, so he is already compromised. V15 said staff should be more vigilant with a patient like R2. R2's 4/2/25 wound assessment by V15 showed an unstageable pressure injury due to necrosis (dead, non-viable skin tissue) measuring 4.1 cm x 6.3 cm. The assessment showed the depth of the wound was not measurable due to presence of nonviable tissue and necrosis. The assessment showed the wound had 100% thick adherent black necrosis tissue (eschar). The treatment initiated was skin prep once daily and as needed for 30 days and recommendations to off-load wound.R2's Medication Review Report from 3/6/25 through 9/4/25 showed an order dated 4/2/25 that read as follows: Right second toe and Right Heel-Cleanse with normal saline, apply skin prep and leave open to air everyday shift.R2's March and April 2025 Medication Administration Records (MARS) and Treatment Administration Records (TARS) were reviewed. R2's March and April MARS and TARS showed the treatment for R2's right heel pressure ulcer was started on 4/3/25.R2's 9/2/25 Wound Evaluation by V15 showed a stage 4 full thickness pressure ulcer to his right heel with a duration of greater than 149 days. On 9/2/25 the wound measured 2.9 cm in length x 3.4 cm width x 0.3 cm in depth. The wound evaluation showed surgical excisional debridement procedure was performed to remove necrotic tissue and establish the margins of viable tissue. The evaluation showed that R2 had a previous surgical debridement procedure performed on 6/26/25.On 6/17/26 at 10:57 AM, V2 (Director of Nursing-DON) said she was looking through R2's progress notes and did not see any documentation of him refusing care, other than refusing some of his medications. At 11:10 AM, V2 (DON) said that with R2 being diabetic and having neuropathy, a pressure injury can be acquired quickly so I would expect staff to be vigilant. V2 said we would see those progressional changes and I would expect them to find it before it was an unstageable pressure injury with eschar.The facility's policy and procedure titled Pressure Injury Prevention and Management, copyright 2026 The Compliance Store, LLC, showed This facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries.2. The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors ; monitoring the impact of the interventions; and modifying the interventions as appropriate.3.c. Licensed nurses will (continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | conduct a full body skin assessment on all residents upon admission/readmission, 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 implemented. D. Assessments of pressure injuries will be performed by a licensed nurse and documented on the (fill in blank for designated form). The staging of pressure injuries will be clearly identified to ensure correct coding on the MDS. E. Nursing assistants will inspect the skin during bath and will report any concerns to the resident's nurse immediately after the task. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>Based on observation, interview, and record review, the facility failed to implement procedures regarding the reconciliation and management/disposal of controlled substances. This applies to 2 of 3 residents (R3 and R4) reviewed for controlled substances in the sample of 11.The findings include:The facility's Final Incident Report (dated 4/30/26) showed, On 4/24/2026 [actual date of discrepancy was 4/23/26, incident was not reported until 4/24/26], during a routine controlled substance count, licensed nursing staff identified two bottles of [antianxiety medication, lorazepam] missing from the medication cart. The medications had documented discontinuation orders for both residents prior to discovery. No discrepancies were identified in medication administration records, and no doses were missed or inappropriately administered. The report identified that the medications had belonged to R3 and R4; however, the medications had been discontinued.The facility's investigation showed R3 and R4's bottles were identical bottles of liquid lorazepam concentrate of 2 milligrams per milliliter.R3's controlled substance count sheet for the missing lorazepam showed it had been delivered to the facility on 5/10/25 and 28.25 milliliters remained in the bottle.R3's physician orders showed the order for his liquid lorazepam had been discontinued on 10/2/25. (6 months prior to when the lorazepam was discovered missing.)R4's controlled substance count sheet for the missing lorazepam showed it had been delivered to the facility on 4/4/26 and 18.5 milliliters remained in the bottle.R4's physician orders showed the order for his liquid lorazepam had been discontinued on 4/14/26 (9 days prior to the medication being discovered missing.)On 6/16/26 at 11:57 AM, V7 Registered Nurse stated she was working on 4/23/26 and she was responsible for the controlled substance for R3 and R4. V7 stated she was scheduled to work from 2:00 PM to 10:00 PM on 4/23/26; however, the facility was short staffed, and she came in to work from 10:00 AM to 10:00 PM. V7 said that when she arrived at the facility .it was a mess. V7 said she could not get report, medications had not been administered, and there was no one to do a controlled substance count. V7 stated a controlled substance count should be done when a nurse takes over a medication cart and it was not done when she took over R3 and R4's medication cart on 4/23/26 at 10:00 AM. V7 stated, a count was done at 10:00 PM that evening and R3 and R4's discontinued bottles of lorazepam were not in the medication refrigerator. On 6/16/26 at 1:39 PM, V2 Director of Nursing stated V7 should have completed a controlled substance count on 4/23/26 at 10:00 AM. V7 stated nursing staff should do a controlled substance count at shift change and/or whenever another nurse takes control of the medication cart. V2 stated R3 and R4's lorazepam should have been destroyed when the medications were discontinued. V2 said the purpose of controlled substance counts and destroying discontinued controlled substances is to minimize the risk of drug diversion.The facility's controlled Substance Administration and Accountability policy (copyright 2025) showed, It is the policy of this facility to promote safe, high quality patient care, compliant with state and federal regulations regarding monitoring the use of controlled substances. The facility will have safeguards in place in order to prevent loss, diversion or accidental exposure. For areas without automated dispensing systems, two licensed nurses account for all controlled substances and access keys at the end of each shift. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>Based on observation, interview, and record review the facility failed to store controlled substances behind a double lock allowing activity staff to enter an area with controlled substances. This applies to 2 of 3 residents (R3 and R4) reviewed for controlled substances in the sample of 11.The findings include:The facility's Final Incident Report (dated 4/30/26) showed, On 4/24/2026 [actual date of discrepancy was 4/23/26, incident was not reported until 4/24/26], during a routine controlled substance count, licensed nursing staff identified two bottles of [antianxiety medication, lorazepam] missing from the medication cart. The medications had documented discontinuation orders for both residents prior to discovery. No discrepancies were identified in medication administration records, and no doses were missed or inappropriately administered. The report identified that the medications had belonged to R3 and R4; however, the medications had been discontinued.The facility's investigation showed R3 and R4's bottles were identical bottles of liquid lorazepam concentrate of 2 milligrams per milliliter.R3's controlled substance count sheet for the missing lorazepam showed it had been delivered to the facility on 5/10/25 and 28.25 milliliters remained in the bottle.R3's physician orders showed the order for his liquid lorazepam had been discontinued on 10/2/25. (6 months prior to when the lorazepam was discovered missing.)R4's controlled substance count sheet for the missing lorazepam showed it had been delivered to the facility on 4/4/26 and 18.5 milliliters remained in the bottle.R4's physician orders showed the order for his liquid lorazepam had been discontinued on 4/14/26 (9 days prior to the medication being discovered missing.)On 6/16/26 at 11:57 AM, V7 Registered Nurse stated she was working on 4/23/26 and she was responsible for the controlled substance for R3 and R4. V7 stated she was scheduled to work from 2:00 PM to 10:00 PM on 4/23/26; however, the facility was short staffed, and she came in to work from 10:00 AM to 10:00 PM. V7 when she arrived at the facility .it was a mess. V7 said she could not get report, medications had not been administered, and there was no one to do a controlled substance count. V7 said the refrigerator lock which housed R3 and R4's lorazepam had been broken for weeks prior to 4/23/26. On 6/16/26 at 1:18 PM, V9 Human Resources stated she was tasked with reviewing security camera footage for the medication room containing R3 and R4's missing controlled substances. V9 stated, for the date of 4/23/26, the footage showed V8 Activity Aide entering the medication room without a key. V9 stated she could not see what V9 was doing in the room. V9 said no other unqualified staff entered the medication room during the time when R3 and R4's discontinued lorazepam was identified to have gone missing.On 6/16/26 at 10:40 AM, V20 Housekeeping Supervisor stated she observed V8 enter the medication room on 4/23/26. V20 stated V8 exited the room with a garbage bag with only a few items in the bag. V20 stated she confronted V8 and V8 stated she was cleaning up garbage. V20 said there was no nursing staff with V8. V20 said V8 then exited the building with the bag of garbage. V20 said only nurses are supposed to enter the medication room and she does not know how V8 gained entrance.On 6/16/26 at 1:04 PM, R5 stated he had witnessed an activity person entering the medication room. R5 stated he thought it was odd as he knew only nurses were supposed to go into the medication room. R5 stated the activity aide opened the fridge; however, he could not see if she removed anything.On 6/16/26 at 1:39 PM, the medication room for R3 and R4 was observed with V2 Director of Nursing. The door to the room was locked, the refrigerator had a pad lock, and there was a locked plexiglass box in the fridge containing controlled substances. V2 stated, when R3 and R4's lorazepam went missing, the lock on the fridge was not working and she believes the plexiglass box was not properly locked either. V2 stated only nurses should have access to the medication room. V2 said if housekeeping needs to clean the medication room, a nurse needs to open the door for them and stay in the room while they are in there. V2 said controlled substances, like lorazepam, need to be double locked and on 4/23/26 they were not. V2 said the purpose of the locks is to prevent drug<br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | diversion.The facility's controlled Substance Administration and Accountability policy (copyright 2025) showed, It is the policy of this facility to promote safe, high quality patient care, compliant with state and federal regulations regarding monitoring the use of controlled substances. The facility will have safeguards in place in order to prevent loss, diversion or accidental exposure. Patient-specific controlled substances (e.g., narcotic/epidural infusions, tablets, etc.) are stored under double lock until administered to the patient . If any unauthorized person is seen lingering around a location where controlled substances are stored, call the Police. |