

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  146041	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/26/2024
NAME OF PROVIDER OR SUPPLIER  Allure of Moline		STREET ADDRESS, CITY, STATE, ZIP CODE  430 South 30th Avenue East Moline, IL 61244	

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)
<p>F 0602</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34542</b></p> <p>Based on record review and interview, the facility failed to ensure resident funds were not misappropriated from resident account for one resident (R1) of three residents reviewed for resident funds. The facility failed to protect R1, a resident with diagnoses of bipolar disorder and autistic disorder, from theft and exploitation when V5 opened an account in R1's name and withdrew \$11,900.00. This failure would result in a reasonable person experiencing anger and anxiety from having a large sum of money removed from their account without their consent.</p> <p>FINDINGS INCLUDE:</p> <p>Facility policy, entitled Abuse, Neglect, and Exploitation, dated 2023, document, Misappropriation of Resident Property. means that deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent.</p> <p>R1's Electronic Medical Record document R1's diagnosis to include: Bipolar II Disorder, Epilepsy, Diabetes Mellitus Type II, Autistic Disorder, Unspecified Fall, Dysphagia, Suicidal Ideation, Intermittent Explosive Disorder, Gastro-Esophageal Reflux Disorder, Cleft Palate, and Obstructive Sleep Apnea; and R1's Quarterly Minimum Data Set, dated [DATE], document R1's Brief Interview for Mental Status as 15/15, which indicates R1 is cognitively intact.</p> <p>The facility's final report, submitted to the State Agency on 4/3/2024, documents: Investigation ongoing, Family is not willing to cooperate with staff on investigation progress, however, police report was filed. Previous BOM [V5/Former Business Office Manager] helped resident set up an ABLE (Achieving a Better Life Experience) account debit card, and per the resident and family, [V5] had access to the account; and information, from [Bank] document the following amounts were transferred from R1's ABLE account to V5's [personal electronic money account]: 3/4/24-1K [\$1000.00]/1K/1K/1K; 3/5/24-2K, 3K; 4/1/24-\$100/100/200/500/500/1500. All totaled \$11,900.00.</p> <p>On 4/25/24, a written statement, provided by V1/Administrator-in-Training, document, Thursday 3/7/24, [V5] exited her office, across from mine, kind of looked at me sadly. I asked if she was OK, she stated Yes, I am just not feeling too well and am going to leave a little early to get some cold meds and go home. She did not return to work the next day. Made several attempts to reach out without success. -3/11/24, [R1] let us know he was expecting a new debit card. -3/28/24 [R1's] father came to the facility to see me, I was at a conference, so he left and filed a police report because he received a statement from his son's account that only reflected a small amount of money, rather than the almost \$12,000.00 that was supposed to be in there. This was reported to [State Agency] 3-28-2024.</p> <p>(continued on next page)</p>

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 0602  Level of Harm - Actual harm  Residents Affected - Few	On 4/25/24, at 1:25 p.m., V4/Regional Nurse confirmed V5 should not have taken R1's funds and V5's employment was terminated.