

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 05/07/2025
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30899</p> <p>Based on interview and record review the facility failed to prevent resident to resident physical assault for one resident (R5) of four residents reviewed for abuse in the sample of 27.</p> <p>Findings include:</p> <p>Facility Policy/Abuse, Neglect and Exploitation dated 2025 documents:</p> <p>It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.</p> <p>Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations.</p> <p>Physical abuse includes, but is not limited to hitting, slapping, punching, biting and kicking.</p> <p>Final Incident Investigation Report dated 4/21/25 indicates R6 reached out and struck R5; residents separated immediately. R6 placed on 1:1 supervision until transported out of the facility to a behavioral hospital for evaluation.</p> <p>Nurse Note dated 4/15/2025 at 4:34pm indicates R6 argued and attempted to strike R16. Staff removed R16 to de-escalate the situation when he heard resident R5 talking to himself. R6 assumed R5 was talking about him and R6 began to yell and struck R5 on the arm. Staff intervened and separated both residents.</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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/7/25 at 11:00am V9, CNA (Certified Nurse Assistant) stated (on 4/1/5/25) she was sitting down D-Hall when she heard R6 shouting from the dining room. V9 stated as she responded to the dining room, she saw V11, LPN (licensed Practical Nurse) moving R16 away from R6 and then witnessed R6 hit R5 with his fist before she could get to R5 to remove him from proximity to R6. V9 stated because of her angle, she could see R6 strike R5 but could not see exactly where R6 made contact with R5's body. V9 stated somewhere around (R5's) chest or arm. V9 stated that she then pulled R5 away from R6 as R5 was in a wheelchair and R6 was standing. V9 stated R5 did not have any reaction to being struck by R6 and no injuries were found after R5 was assessed. V9 stated R6 continued yelling, shouting and cussing which is (R6's) usual behavior. V9 stated she believes R6's primary language is Spanish and that he gets easily frustrated when he isn't understood. V9 stated she accompanied R6 to the hospital and the hospital physician spoke Spanish to R6 and he seemed happy.</p> <p>On 5/6/25 at 2:15pm R5 was observed in his bed, R5 was unable to answer questions appropriately; speech was garbled and mostly incoherent.</p> <p>On 5/6/25 and 5/7/25 R5 was seen in a wheelchair in the dining room during lunch meals.</p> <p>Abuse/Neglect/Trauma assessment dated [DATE] indicates R5 is at moderate risk for potential future problems related to mistreatment.</p> <p>Comprehensive assessment dated [DATE] indicates R5 has diagnosis of Alzheimer's dementia and is severely cognitively impaired.</p> <p>R5's current Care Plan indicates R5 has a communication deficit related to hearing loss and cognitive impairment.</p> <p>On 5/6/25/25 and 5/7/25 R6 was observed ambulating in the dining room and appeared to be preoccupied.</p> <p>Abuse/Neglect/Trauma assessment dated [DATE] indicates R6 is at moderate risk for potential future problems related to mistreatment.</p> <p>Comprehensive assessment dated [DATE] indicates R6 has diagnosis of Paranoid Schizophrenia and has moderate cognitive impairment.</p> <p>R6's current Care Plan indicates R6 Behaviors Risk with the potential to be verbally aggressive, such as yelling/cursing at staff and residents and has aggressive behavior toward others.</p> <p>Current Care Plan does not include communication/language problem or identify Spanish as R6's Primary language.</p> <p>Nurse Notes indicates that on 4/9/25 and 3/30/25 R6 had to be redirected after yelling and putting up fist at other residents with attempts to strike them.</p> <p>3/28/2025 17:45 (5:45 pm)</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Nurse Note dated 3/28/2025 at 5:45pm indicates R6 has had an increase in behaviors. Staff has had to step in between him and other residents multiple times this shift due to aggressive behaviors and attempting to strike at other residents.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>30899</p> <p>Based on observation, interview and record review the facility failed to provide hot water at comfortable temperatures for 22 residents (R4-R25) who reside on D-Hall of 22 residents reviewed for water temperatures in the sample of 27.</p> <p>Findings include:</p> <p>On 5/6/25 at 10:15am V5, CNA (Certified Nurse Assistant) stated there is no hot or even warm water in any of the rooms on D-Hall It's been like this for about a month. V5 stated We have to go to the nurses station to get hot water to clean residents that we get up in the morning.</p> <p>On 5/6/25 at 10:25am R4 stated that the CNA's have to get hot water from the nurses station to clean him up. R4 stated there have been times they used the bathroom sink water from his bathroom and it was cold and uncomfortable. R4 stated all the CNA's know about No hot water, its been like this for at least a month.</p> <p>On 5/6/25 at 11:35am V5, Maintenance Director used a digital thermometer to check the hot water temperature in the bathroom sink in R4's room. After approximately three minutes the hot water reached a maximum of 76 degrees F (Fahrenheit). Water temperature was also checked across the hall in a currently occupied resident room/bathroom sink and after approximately three minutes reached a maximum of 76 degrees F.</p> <p>On 5/6/25 at 11:40am V5, Maintenance stated the nurses told me 1-2 weeks ago and said residents were complaining of cold water on D-Hall. V5 stated he does take water temperatures and sometimes the water would warm up after about 5-10 minutes. V5 acknowledged that 5-10 minutes is a long time to wait for hot (warm) water and whether it gets warm has been inconsistent. V5 stated they had new water pipes put in about a month ago and the lack of hot water on D-Hall might have to do with that installation. V5 stated I notified (Corporate Maintenance Director) and checked the equipment he told me to, but we have not called for outside assistance.</p> <p>Water Management Program/Point of Use Water Temperature Logs indicate:</p> <p>Note Hot Water temperature below 105 degrees F or Cold Water above 67 degrees F as outside control limits.</p> <p>4/3/25 D Hall room Hot water temperature 107.1 degrees F</p> <p>4/21/25 D Hall (2 rooms) Hot water temperatures 49 degrees F and 58 degrees F</p> <p>4/28/25 D Hall (2 rooms) Hot water temperatures 50 degrees F and 60 degrees F</p> <p>5/6/25 D Hall (2 rooms) Hot water temperatures 74 degrees F and 76 degrees F</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/7/25 at 1:15pm V5, Maintenance stated hot water temperatures should be between 100 and 110 degrees F.</p> <p>The facility provided an undated resident roster that showed R4-R25 resided on the D wing of the facility.</p> <p>Facility Policy/Safe Water Temperatures dated 2025 documents:</p> <p>It is the policy of this facility to maintain appropriate water temperatures in resident care areas.</p>		