STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146041	A. Building B. Wing	08/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allure of Moline	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)
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. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure a resident with dysphagia (difficulty swallowing) on a puree diet was supervised in the dining room. This failure allowed R1 to move through the dining room and consume solid foods from resident trays, resulting in him choking and expiring. This applies to 1 of 3 residents (R1) reviewed for safety and supervision in the sample of 4.The Immediate Jeopardy began on 8/9/25 when R1 was unsupervised in the dining room, choked on food and expired. V1 Administrator was notified of the Immediate Jeopardy on 8/19/25 at 8:10 AM. The surveyor confirmed by observation, interview and record review that the Immediate Jeopardy was removed, and the deficient practice corrected, on 8/11/25, prior to the start of the survey and was therefore Past Noncompliance. The findings include:R1's admission record shows he was admitted to the facility on [DATE] with multiple diagnoses including cerebral infarction due to unspecified occlusion or stenosis of unspecified anterior cerebral artery, hemiplegia (partial paralysis), unspecified affecting right dominant side, aphasia (difficulty speaking) following cerebral infarction, and dysphagia (difficulty swallowing), oral phase.R1's August order summary report documents a diet order for a general diet with a pureed texture and nectar consistency liquids. Double portions, fortified ice cream twice daily. Up in chair for all intakes. Must be supervised closely in dining room for taking food. Patient with choking and aspiration risks. R1's annual Resident Assessment and Care Screening of 8/6/25 documents him to have moderate cognitive impairment. His functional abilities assessment showed he uses a wheelchair for mobility. The same assessment documented he required supervision for eating.R1's care plan documents a swallow risk related to dysphagia and Cerebrovascular Accident (CVA). At risk for choking due to removing food and eating from other resident's trays that is not on prescribed diet, attempts to eat nonfood items. The interventions include R1 was to only eat with supervision. R1's nursing progress note of 8/9/25 showed he finished his pureed dinner, and he was cleaned up and self-propelled across the dining area towards his room on D hall. At approximately 6:45 PM, V6 Certified Nursing Assistant (CNA) noted R1 sitting at the beginning of the hallway in obvious distress, face pale in color. Two CNAs rushed to assist resident and noted he was choking and started the Heimlich maneuver immediately. V1 Licensed Practical Nurse (LPN) was alerted and intervened. A partial bolus of food was removed from his mouth and the Heimlich was continued. Emergency Medical Technicians (EMTs) arrived on the scene and assumed intervention including suctioning, IV medications, chest compressions, and intubation. These efforts were futile and R1 was pronounced dead at 7:27 PM. On 8/17/25 at 8:15 AM, the dining room was observed to be a large open room. Upon entrance, A wing was directly to the left, then following around the room to the right was B wing, and C wing was located straight from the entryway. Followed by D wing then to the right was E wing. A short pony wall surrounded the dining area with room to move around the room behind the walls. Nurses had their carts behind the walls preparing and passing medications. Staff were serving breakfast.On 8/17/25 at 8:20 AM, V7 LPN said R1 was on a pureed diet, and was able to feed himself. She said he was on a puree diet due to the weak muscles in this throat following a stroke. He was alert but non-verbal. He seemed to understand what was being said to him, and he knew he was not supposed to have solid foods. He would always be grabbing and sneaking food off of trays and hurry and stuff it in his mouth. V7 said R1 could propel the wheelchair himself with his left foot. She said sometimes the staff would take him out of the dining room and he would just go back in, and he would grab at food.On 8/17/25 at 11:00 AM, V5 CNA said R1 was alert and always did his own thing and did not like to listen. He did not speak; he used a lot of hand motions. She said R1 was on a puree diet, and he could feed himself, and he also had thickened liquids. He would try to take food mainly from the snack cart or food left on tables. We reminded the independent residents not to leave food behind. She said R1 was non-complaint with his puree diet and was quick to grab anything and try to eat. She said there was no special rules or procedures to ensure he left the dining room without grabbing food as he was leaving. She said it was just common knowledge among the aides to just keep an eye on him because of his behaviors of grabbing at food.On 8/17/25 at 11:20 AM, V6 CNA said she has witnessed R1 snatching food such as a pork tenderloin sandwich and a burger. She said R1 was able to feed himself and propel himself, and he did need to be watched when he was leaving the dining room. When he would get food he would stuff it in his mouth really fast because he knew he was not supposed to have it. V6 said on 8/9/25 she was in the dining room for the dinner meal and had her back turned while feeding other residents. She did not know where R1 was located