

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 11/26/2025
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)		
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview and record review the facility failed to prevent abuse for two residents (R5 and R8) of three residents reviewed for abuse in a total sample of forty-two. The Facility's undated Abuse, Neglect and Exploitation policy documents 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 prevent abuse, neglect, exploitation and misappropriation of resident property. 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. 1.The Facility's Final Investigative Report dated 11/10/25 documents that R6 pushed R8 into a wall. On 11/25/25 at 2:30 PM R8 confirmed that he was pushed by R6 some time ago. R8 stated I ran into the wall. R8 stated I was relatively new to the place and did not realize once (staff) announce it is time for a smoke break that some of them (other residents) will run for the door. (R6) wanted me out of his way pronto. Throughout the survey R6 refused to speak to this surveyor. V5 (Licensed Practical Nurse) stated (R6) only speaks when he wants to. It is normal for him to not answer questions when he is asked. 2.The Facility's Final Investigative Report dated 11/24/25 documents that R7 struck R5 on the arm. The investigation documents that R5 has a history of mumbling to himself and making noises randomly which then annoyed R7 who struck him on the arm. Throughout the survey R5 did not answer any questions. R5 was noted to be mumbling incoherently and making clicking noises. On 11/25/25 at 2:45 PM R7 confirmed he lightly smacked R5's arm. Those noises are annoying. On 11/26/25 V1 (Administrator) confirmed that the allegation of physical abuse regarding R6 and R8 dated 11/10/25 and the allegation dated 11/24/25 regarding R7 and R5 would be considered substantiated because they did happen.		

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation, interview and record review the facility failed to securely store medications for two residents (R15 and R21). This failure has the potential to affect all medications being stored in the E Hall cart (R5,R6 and R9 through R42.)The Facility's undated Medication Storage documents It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light and ventilation, moisture control, segregation and security. On 11/25/25 at 8:45 AM V5 (Licensed Practical Nurse) was in the main dining room with two clear medication cups with pills in them in one hand and a glass of tan brownish liquid. V5 handed the glass of liquid to a resident then stopped and handed medications to R15 and then handed another cup to R21. On 11/25/25 at 9:15 AM V5 (LPN) stated that she forgot to give a resident his protein drink, so she dropped that off and then administered R15 and R21's medications. V5 stated that the medication cups contained all of R15 and R21's scheduled 8:00 AM medications. R15's Medication Administration Record dated November 2025 documents R15's scheduled 8:00 AM medications as Gabapentin 100 mg (milligrams), Aspirin 81 mg, Baclofen 10 mg, Multiple Vitamins with Minerals, Pepcid 20 mg, and Senna Tablet 8.5 mg. R21's Medication Administration Record dated November 2025 documents R21's scheduled 8:00 AM medications as Famotidine 20 mg, Lithium Carbonate 150 mg, Ascorbic Acid 500 mg, Aspirin 325 mg, Potassium Chloride 20 meq (milliequivalents), Vitamin D3 2000 Units, Eye-Vites (multivitamins), mucus relief 400 mg. On 11/25/25 at 10:00 AM V1 (Administrator) stated All medications should be kept in the carts and the nurses should only pass one person's medications at a time to avoid possible medication errors.		