STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0056713	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allure Of Moline	**430 SOUTH 30TH AVENUE , EAST MOLINE, Illinois, 61244**

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S0000	Initial Comments Investigation of Facility Reported Incident of 8/9/25/2587093	S0000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 300.1210b) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The	S9999		09/02/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These requirements were not met as evidenced by: 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. This past non-compliance occurred between 8/9/25 and 8/11/25. R1's admission record shows he was admitted to the facility on 3/16/22 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.	S9999		

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S9999	Continued from page 2 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.	S9999		

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S9999	Continued from page 3 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 at the time. She said call lights were going off on D wing, so her and V3 CNA decided to go check. She said as she was walking towards D wing she noticed R1 and he appeared to be choking. She began doing back thrusts and the Heimlich maneuver. She said it appeared bread and hot dogs were in his mouth. On 8/17/25 at 11:36 AM, V3 said she did see him once trying to take a sandwich off of another resident's tray. If he was leaving the dining room and seen a plate, he would try and take food. He wandered in his wheelchair and able to go wherever he wanted. She said the staff would monitor him but could not watch him 24/7. She said in the dining room there would be 2-3 aides sitting at a table assisting residents to eat. V3 said R1 would sit in the dining room closer to the B wing entrance and would take himself out of the dining room. Sometimes he would go around the short wall of the dining room or through it. There was no set process or procedure. V3 said she was walking with V6 towards D wing when they noted R1 to be choking and she assisted with resuscitation measures, but R1 expired. V3 said she was speaking with V4 LPN and heard her say she had just passed R1 and he had food in his mouth but did not do anything. On 8/17/25 at 12:30 PM, V4 said R1 was on a puree diet and had behaviors of taking food from the dining room	S9999		

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S9999	Continued from page 4 tables. She did not see him before the choking incident on 8/9/25. She said R1 was able to move himself through the facility. There was no procedure or protocol in place at that time to ensure he got out of the dining room without stealing food from plates. On 8/17/25 at 2:30 PM, V1 Administrator said she was working as an LPN the night of the incident. She said during the meal service, she recalls R1 was in the dining room at his table near the entrance of B wing. He was eating his pureed diet and able to move himself around. V1 said she was at the nurse's station when she heard staff calling for help. She saw V3 and V6 giving back thrusts and performing the Heimlich maneuver, and it was not helping. She said you could tell his mouth was full of food, and as she was pulling it out, it appeared to be hot dogs and buns. V1 said 911 was called, and she continued efforts to get the food out. When the EMTs arrived, they tried to intubate him, but could not get the tube in, and R1 could not breathe. She said the EMTs tried for 40 minutes, but R1 expired. V1 said R1 was always trying to get food off plates in the dining room. Most of the time residents will yell out at the staff to alert us to him stealing food. She said none of the residents ever said anything. V1 said R1 was sat next to those residents needing fed, but he moved so fast. He must have picked up food while he was moving through the dining room. All of the CNAs are to be in the dining room and passing trays. During that time, R1 needed better supervision. Everyone is supposed to be monitored. Should have been watching (R1) and taking him out of the dining room. We did fail him somewhere, I guess. The facility's revised 8/11/25 policy for meal supervision and assistance documents The resident will be prepared for a well-balanced meal in a calm environment, location of his/her preference and with adequate supervision and assistance to prevent accidents, provide adequate nutrition, and assure an enjoyable event. This includes: 1. Identifying hazards and risks 2. Evaluating and analyzing hazards and risks 3. Implementing interventions to reduce hazards and risks 4. Monitoring for effectiveness and modifying interventions when necessary. The deficient practice was corrected on 8/11/25 after the facility: Audited care plans of all the residents requiring modified diets, and supervision while eating. All care plans have been reviewed and modified for accuracy. Environmental review of the dining room completed on 8/10/25 and table changes made as necessary as well as identified residents at risk, are now escorted from the dining room after meals.	S9999		

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S9999	Continued from page 5 Residents on a pureed diet will be seated together for resident dignity and safety/supervision with a staff member assigned to their table. On 8/11/25 all licensed nursing staff were in-serviced on the facility policy for Meal Supervision and Incidents and Accidents. On 8/11/25 an emergency Quality Assurance and Performance Improvement (QAPI) meeting was held with the medical director. Hot Dogs will no longer be served in the building, and an adequate replacement has been implemented. Quality Assurance (QA) tools developed post QAPI to ensure quality and compliance. New staff will receive the education during their onboarding process. (A)	S9999		