

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057786		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/17/2026	
NAME OF PROVIDER OR SUPPLIER Allure Of The Quad Cities				STREET ADDRESS, CITY, STATE, ZIP CODE 833 SIXTEENTH AVENUE , MOLINE, Illinois, 61265			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
S0000	Initial Comments			S0000			
	Investigation of Facility Reported Incident of 2/10/26/2786846						
S9999	Final Observations			S9999			
	Statement of Licensure Findings:						
	1 of 2						
	300.610a)						
	300.1210b)						
	300.3210t)						
	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						
	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.						
	Section 300.3210 General						
	t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 These requirements are not met as evidenced by: Based on observation, interview, and record review, the facility failed to protect cognitively impaired residents (R7, R5, R6) from sexual abuse by another resident (R4) with a known pattern of sexually inappropriate behaviors. R4 was observed with her hand on R7's vaginal area. R4 was observed with her whole hand inside R5's pants in his penile area. R4 was observed with her hand in R6's groin moving towards his penile area in a tapping motion up and down. This failure applies to 4 of 13 residents (R4, R7, R5, R6) reviewed for abuse in the sample of 14. The findings include: R4's face sheet shows R4 was admitted to the facility on 7/31/23 with diagnoses that include cerebral infarction (stroke) dementia and congestive heart failure (CHF). R4 was on hospice services due to CHF. R4's facility assessment dated show 2/5/26 shows R4 has moderately impaired cognition. R4 uses a wheelchair to self-propel and requires maximum assistance from staff for her activities of daily living (ADL's). On 3/13/26 at 9:45 AM, R4 was sitting in her wheelchair alert and smiling. R4 was away from the male residents in the common area. When asked how she was doing, R4 said she was doing well. 1.R4's progress notes dated 11/22/25 by V5 (Registered Nurse-RN) shows, "R4 was observed in hallway having expressions of sexual behaviors. R4 was observed wearing a vinyl glove from nurses' cart. R4 had approached another resident (R7) in same hallway and began to fondle resident's labia." R4 and R7 were separated. R7's face sheet shows R7 was admitted to the facility on 9/29/22 with diagnoses that include dementia and cancer of the bladder. R7's facility assessment dated 2/17/26 shows R7 has severe cognitive impairment. R7 is wheelchair bound and dependent on staff for ADLs. During the noon meal, R7 was eating lunch in the same dining room as R4. R7 was unable to answer questions. On 3/13/26 at 12:45 PM V5 (RN) said she was the Nurse on 11/22/25, this incident happened while R4			S9999			

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S9999	Continued from page 2 was in the B wing. On 11/22/25, R4 was sitting in her wheelchair in the B wing hallway. R7 was also sitting in her wheelchair in the B wing hallway. R4 was observed taking a glove from a cart, placed her gloved hand and fondled R7's vaginal area in the hallway. V5 said R4 was taken away from R7 immediately. V5 said she felt bad for R7 who has dementia and was not aware that she was touched inappropriately. When resident touches another resident in their private area, that is sexual abuse. R4 and R7 were now moved in the dementia unit. R4's care plan (undated) did not address this sexual behavior dated 11/22/25 towards R7 with no interventions put in place for R4's sexual abuse to prevent further occurrence of abuse. R7's care plan dated 9/22/25 documents R7 was low risk of abuse with diagnosis of dementia with depression and anxiety. R7's care plan had no updated interventions in place to protect R7 from sexual abuse. 2. A Facility Reported Incident dated 2/23/26 as final (with the date of incident as 2/10/26) documents "R4 was sitting by R5 and staff observed her with hand near his waist resident immediately separated. R5 was placed on 15-minute checks. R4 was placed on 1:1". R5's face sheet documents R5 was admitted to the facility last 5/9/25 with diagnoses that include dementia, depression and diabetes. R5's facility assessment dated 1/30/26 shows R5 was severely cognitively impaired. R5 needs assistance with his ADLs due to dementia. On 3/13/26 at 9:50 AM, R5 was sitting in his wheelchair watching TV quietly. R5 said he was fine. On 3/13/26 at 12 PM, V13 (RN) said she was the Nurse in the Dementia unit on 2/10/26. V13 said she was passing the 5PM medications when she looked up and saw R4 wheeling herself fast towards R5. R5 was sitting in his wheelchair. R4 put her whole hand inside R5's pants towards R5's penile area. V13 said she yelled "take R4 away from R5 now!" When R5 was wheeled away from R4, R4 was so upset yelling and screaming that she wanted to go back to R5. V5 said she notified V3 (Assistant Director of Nursing- ADON) immediately. R4 was placed on 1:1. V13 said R5 had no reaction to what had just happened to him due to dementia but that was sexual abuse. Residents are to be free and protected from any kind of abuse. Residents should be safe.			S9999			

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S9999	Continued from page 3 On 3/13/26 at 11:30 AM, V4 (Activity Aide) said on 2/10/26 she heard the nurse screaming to move R4 away from R5. V4 said she saw R4's hand inside R5's pants inside his undergarments touching R5's penile area. V4 said she hurriedly moved R4 away from R5. R4 was upset and she wanted to return to R5. On 3/13/26 at 11:15 AM, V3 (ADON) said it was reported to her regarding R4 having behaviors of sexual aggressiveness when she put her hand inside R5's pants. This was reported to the Administrator (V1) exactly how it happened (R4 touching R5's penile area not just waist). V3 said she instructed staff to closely supervise R4, placing her 1:1 supervision to ensure R4 does not sexually abuse R5 again. V3 said Hospice was also notified. R4's care plan (undated) did not address this sexual behavior dated 2/10/26 towards R5 with no intervention put in place R4's sexual abuse to prevent further occurrence of abuse. R5's care plan dated 2/24/26 documents R5 was moderate risk for abuse related to poor cognition (dementia). R5's care plan had no interventions in place to address R5 being sexually abused last 2/10/26, no interventions in place to protect R5 from sexual abuse. 3. The facility's Reported incident sent to the state agency as initial dated 3/11/26 show, "there has been a resident-to-resident incident. Residents separated immediately. No injuries and no distress observed. Physician and both POA's notified. 5 days to follow." R6's progress notes dated 3/11/26 shows R4's hand was noticed in groin area outside of clothing on a male resident (R6). Staff immediately intervened and separated them. The other resident (R6) did not appear to be in any distress. She (R4) is now on 15 min checks and will be under increased supervision while in common area. R6's face sheet shows R6 has diagnoses that include Alzheimer's dementia, bipolar disorder and hypertension. R6's facility assessment dated 12/11/25 shows R6 is severely cognitively impaired. On 3/13/26 at 9:55 AM, R6 was sitting in his wheelchair alert, smiling and had no complaints.	S9999					

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S9999	Continued from page 4 On 3/17/26 at 10:32 AM V12 (License Practical Nurse-LPN) said she was the Nurse on 3/11/26 PM shift. It was around 4:30 PM, V4 (Activity Aide) was wheeling R4 towards her. V12 (LPN) said R4 and R6 were both sitting in their wheelchairs side by side. R4 was observed to have placed her hand in R6's groin area towards his private area tapping her hand up and down. Both R4 and R6 were immediately separated. R4 was yelling and screaming while being wheeled away from R6, "I want to f--- him! I want to f---k him! I'll do whatever I want to do" repeatedly. On 3/13/26 at 11:30 AM, V4 (Activity Aide) said on 3/11/26 it was during activity in the common area, residents were watching TV. R4 and R6 were sitting by each other. R4 had her hand in R6's groin to R6's private area while moving her hand up and down. R6's eyes were wide open looking around as if looking for help. V4 said she immediately moved R4 away from R6 and wheeled R4 towards the Nurse (V12). R4 was so upset yelling repeatedly "I want to f--k him, I want to f--k him"! R4's care plan (undated) did not address this sexual behavior dated 3/11/26 towards R6 with no interventions put in place regarding R4's sexual abuse to prevent further occurrence of abuse. R6's care plan dated 1/26/26 documents R6 was at high risk for abuse related to diagnosis of dementia, increased vulnerability due to mental health diagnosis of bipolar and PTSD. R6's care plan had no interventions in place to address R6 being sexually abused on 3/11/26, no interventions in place to protect R6 from sexual abuse. On 3/13/26 at 12:30 PM, V6 (RN) said she was the regular Nurse in the dementia unit. R4 came from another hall (B wing), she was moved to the Dementia unit beginning of this year (2026). R4 has been hypersexual, touching other residents in their private areas. R4 was a hospice patient, wheelchair bound and is able to wheel self around. V6 said when R4 placed her whole hand inside R5's pants touching R5's private area on 2/10/26, she was placed on 1:1. R4's monitoring then became every 15 minutes. A few days ago, (3/11/26) R4 again touched another resident R6 in his private area even if she was supposed to be on 15 minutes check. R4 should just have been on 1:1. V6 said R4 has had no new interventions to her sexual behaviors on 2/10/26 or on 3/11/26 incidents. There have been no med changes to address R4's sexual behaviors. On 3/13/26 at 10 AM, V9 (Certified Nursing			S9999			

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S9999	Continued from page 5 Assistant-CNA) said R4 was now being kept away from other residents. R4 had been touching other residents in their private areas. R4 has also been heard saying "lick my p---y" to other residents. On 3/17/26 at 10:08 AM, V14 (Dementia Director/Social Service) said when abuse occurs, a Trauma Assessment should have been done right away to immediately assess the emotional and psychological results of the abuse and help with supportive interventions. V14 said there was no trauma assessments done on R7 (incident on 11/22/25 in B wing), there was no trauma assessment done and R5 (incident on 2/10/26) and there was no trauma assessment done on R6 (incident on 3/11/26). On 3/13/26 at 11:20 AM, V2 (Director of Nursing-DON) said he became DON last 11/2025. V2 said all he knew was R4 has inappropriately touched residents in the dementia unit. On 3/17/26 at 12:04 PM, V1 (Administrator) said she was the Abuse Coordinator and reports all abuse occurrences to the state agency. V1 said she cannot recall the details of what she reported to the state agency regarding R4, R7, R5 and R6. V1 said she was not at the facility to review the reportable incidents she sent to the state agency. (V1 was not at the facility during these investigations.) V1 said sexual abuse was not tolerated at the facility. On 3/13/26 at 3:45 PM, V18 (Regional Director of Operations) said R4, R7, R5 and R6's care plans should have been updated when the incidents happened to ensure proper interventions were put into place. All residents should be safe and free from harm including sexual abuse. V18 said care plans will be updated today-3/13/26. On 3/17/26 at 11:07 AM, V15 Physician regarding R4, R7, R5 and R6, said he was made aware of the sexual abuse of R4 to R7, R5 and R6 last 3/13/26. V15 said he expects the facility to have close supervision of residents to prevent abuse from happening. The facility policy on Abuse, Neglect and Exploitation (undated) documents, it is the policy of this facility to provide protection for the health, welfare and the right of each resident by developing and implementing policies and procedures that prohibit and prevent abuse neglect exploitation and misappropriation of residence property. Abuse means the willful infliction of injury, unreasonable confinement, intimidation or punishment resulting in			S9999			

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S9999	Continued from page 6 physical harm, pain or mental anguish which can include staff to resident abuse and certain resident to resident altercation. Instances of abuse of all residents irrespective of any mental or physical condition cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse and mental abuse including abuse facilitated for a neighbor through the use of technology. Sexual abuse-Is a non-consensual sexual contact of any type with a resident. "A" 2 of 2 300.610a) 300.1210b) 300.1210d)5) 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 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: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without	S9999					

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S9999	Continued from page 7 pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. These requirements are not met as evidenced by: Based on interview and record review, the facility failed to implement interventions to prevent a resident from developing Stage 4 pressure wounds, failed to assess the wounds in a timely manner, and failed to implement treatment interventions of the wounds for 1 of 3 residents (R1) reviewed for pressure wounds in the sample of 14. These failures resulted in R1 developing wound infections leading to sepsis. The findings include: R1's Face Sheet dated 3/17/26 shows R1 was admitted to the facility on 10/29/25. R1's diagnoses include, but are not limited to, atherosclerotic heart disease, pressure ulcer of left heel, Stage 4, edema, polyneuropathy, pain in right foot, pain in left foot, hypertensive heart and chronic kidney disease, heart failure, acute kidney failure, chronic kidney disease, pressure ulcer of the right heel, Stage 4, anorexia, and abnormal weight loss. R1's care plan provided by the facility initiated on 11/3/25 shows he is at risk for impaired skin integrity due to fragile skin, bilateral lower extremity edema, reduced mobility, and the presence of an indwelling urinary catheter. R1's N Adv-Skin Check dated 11/5/25 at 2:39 PM shows he has a new, in-house acquired wound/blister of his left heel and a new, in-house acquired wound/blister of his right heel. R1's nurse practitioner (NP) documented on 11/6/25 at 1:31 AM that R1 was found to have a stage 4 right heel pressure ulcer and a stage 2 left heel ulcer in the facility. A NP note dated 11/7/25 at 12:00 AM shows R1 was being seen for bilateral foot pains and with numbness with tingling. The note shows R1 has chronic bilateral foot pains and chronic neuropathy (nerve damage causing numbness, tingling, weakness, or burning pain, often starting in the hands and feet) of his feet. R1's Wound-Weekly Observation Tools both dated 11/11/25 at 6:12 PM documented by V3, (Assistant Director of Nursing & Wound Care Nurse), show			S9999			

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S9999	Continued from page 8 R1's right heel, stage 4 pressure ulcer was acquired on 11/11/25 and the assessment is her first observation of the wound and R1's left heel stage 2 pressure ulcer was acquired on 11/11/25 and is also her first observation of the wound. R1's Health Status Note dated 11/10/25 at 1:04 PM shows the following: Family alerted this RN (Registered Nurse) regarding wound on right heel and informing this RN family would like foam boots applied. Foam boots applied to help facilitate pressure off bilateral heels. Float heels in bed: to help facilitate pressure off bilateral heels. Wound nurse notified. R1's Physician Orders show orders written on 11/10/25 to float heels while in bed and to apply foam boots while in bed to help prevent pressure off heels. These two orders were never included in R1's care plan provided by the facility and initiated on 11/3/25. V20's (Wound Care Physician) Initial Wound Evaluation & Management Summary dated 11/11/25 of R1's wounds shows R1 has a Stage 4 pressure wound of the right heel which has been present more than one day and a Stage 2 pressure wound of the left heel which has been present more than one day. V20 removed necrotic tissue (a procedure called debridement) of the right heel wound to reveal the underlying deep tissue at the muscle/fascia level. V20's treatment plan for the right heel wound is Leptospermum honey to be applied once daily and as needed with a gauze island border dressing. R1's Physician Orders shows an order with a start date of 11/11/25 for his right heel to be cleansed with normal saline or wound wash, followed by xeroform gauze to the wound bed and covered with bordered gauze. This same wound treatment was on R1's Medication Administration Record (MAR) for November of 2025 from the dates of 11/12/15 through 11/19/25. The treatment order provided by V20 on 11/11/25 as referenced above was not placed in R1's physician orders on 11/11/25 and was not on R1's MAR or TAR (Treatment Administration Record) for November 2025. R1's Specialty Physician Wound Evaluation & Management Summary dated 11/27/25 shows his left heel wound is now unstageable necrosis. R1's Specialty Physician Wound Evaluation & Management Summary dated 1/6/26 shows R1's left heel wound is debrided and has revealed the underlying deep tissue at the muscle/fascia level, which had been obscured by necrosis previously. The wound has now revealed itself to be a Stage 4 pressure injury. R1's right heel wound is also a stage 4 pressure wound.			S9999			

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S9999	Continued from page 9 On 3/17/26 at 1:12 PM, V20 said her recommendations for wound care treatment should be followed. V20 said if a Stage 2 pressure wound starts as a blister, the natural progression is that it hardens and becomes unstageable necrosis as it dries up. One cannot see if there is further injury underneath. V20 said she believes R1's Stage 2 left heel pressure wound was always a Stage 4 pressure wound, but she could not tell because of the overlying blister and necrosis. On 3/13/26 at 1:21 PM, V3 said she does wound rounds with V20 on Tuesday mornings and V20 will tell her of any wound treatment changes. V3 said the physician's wound notes are uploaded right into the resident's chart and she enters any new orders into the electronic medical record. V3 said new wound treatment orders should be implemented the same day they are ordered. V3 said it is obviously her fault the orders did not get put in for the right heel wound treatment as per V20's recommendations. V3 said staff inform her about any new skin alterations and she goes and does an assessment that day or the following day which includes measuring the wound, noting if there is drainage, if it is wet, and what the wound and area around the wound look like. V3 said R1 had in-house acquired pressure wounds to his right and left heels which were first identified on 11/8/25 by the floor nurse. V3 said R1's heel wounds were caused by pressure against the foot board of his bed; it was not long enough for him, and his heels were pressing against it. V3 said R1 was at risk for pressure wounds. V3 said her first formal assessment of R1's heel wounds was done on 11/11/25; it should have been done the day after they were found. V3 said after R1 acquired the pressure wounds to his heels they implemented interventions including padded booties and she thinks they put an extender on his bed. R1's Health Status Note dated 1/10/26 at 12:14 PM shows R1's family came to get the nurse because R1 did not look OK. The nurse went to assess R1 and he was jerking and responded to his name being called, but could not answer simple questions. R1's vital signs were as follows: oxygen saturation 80 percent on oxygen at 2 liters, blood pressure 130/80, temperature 103, respiratory rate 25. R1 transferred to hospital via emergency medical services. R1's After Visit Summary dated 1/22/26 from his hospital medical records printed 3/16/26 show R1 was admitted to the hospital 1/10/26 with a primary diagnosis of sepsis and discharged 1/22/26. These			S9999			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057786		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/17/2026	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
S9999	Continued from page 10 medical records show a cardiologist consult dated 1/14/26 stating R1 presented to the ED (emergency department) 1/10/26 due to shortness of breath, confusion, fever, and rigors. R1 was admitted with sepsis secondary to urinary tract infection and wound infection. After undergoing imaging studies, R1's ulcerations to R1's right and left heels are concerning for osteomyelitis. R1's blood cultures are positive for ESBL Klebsiella (bacteria). R1 is post excisional debridement of his right and left heels down to and including muscle and bone. The podiatrist note dated 1/12/26 at 7:35 PM shows R1 has necrotic bilateral posterior plantar heel ulcers covered in necrotic, nonviable tissue which was eventually found to be the source of his sepsis. The hospitalist note dated 1/21/26 at 10:45 AM shows R1's intraoperative wound cultures from his right heel is growing vancomycin resistant Enterococcus faecalis and Proteus. The facility's Wound Treatment Management Policy (undated) shows wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change. "B"			S9999			