PRINTED: 03/31/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		164006	B. WING	B. WING		C 01/24/2023	
	ROVIDER OR SUPPLIER EW BEHAVIORAL HEAL	тн		770	REET ADDRESS, CITY, STATE, ZIP CODE D TANGLEFOOT LANE ETTENDORF, IA 52722	1 017	24,2023
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
A 000	000 INITIAL COMMENTS		A	000			
	Centers for Medicare Kansas City Location investigation from 12/compliance with the r 482.12 Condition of F Governing Body; 42 C Rights; and 42 CFR 4 Services, for Complai and Incidents 109166 110066-I. Incidents # 109847-I were found related citations. The in substantial complia at 42 CFR 482.23, Note 482.12, Governing Both Patient's Rights. The survey team idea Jeopardy (IJ) situation The IJ situation was at the health and safety receive adequate nurroversight at risk for opinappropriate sexual a inappropriate behavior others or death. The IJ situation involves to ensure the hospital supervision and asset to provide adequate sinappropriate sexual a patients on the adult on adolescent unit.	7/23 to 1/24/23 to assess equirements under 42 CFR Participation (CoP): CFR 482.13 CoP: Patient's 182.23 CoP: Nursing 182.23 CoP: Nursing 182.23 CoP: Nursing 19391-C, 109525-C; 19-1, 109367-1, 109847-1, and 109166-1, 109367-1, and 109166-1, 109367-1, and 109169-1, and			TITLE		(X6) DATE

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.

Facility ID: IAH0120

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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		164006	B. WING _			01/24	/2023
	ROVIDER OR SUPPLIER EW BEHAVIORAL HEAL	тн		STREET ADDRESS, CIT 770 TANGLEFOOT LA BETTENDORF, IA 5	NE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		_	(X5) COMPLETION DATE
A 000	immediacy of the situ acceptable plan invol precautions, and edu the complaint investig The Conditions of Pa Body (42 CFR 482.12 CFR 482.23), Patient remained out of comp GOVERNING BODY	uccessfully removed the lation by submitting an living staff training on sexual location on the policy prior to gation exit date of 1/24/23. Inticipation for Governing 2), Nursing Services (42 t Rights (42 CFR 482.13), pliance.	A				
	legally responsible for If a hospital does not governing body, the profession for the conduct of the functions specified in governing body This CONDITION is I. Based on documents	persons legally responsible hospital must carry out the this part that pertain to the not met as evidenced by:					
	supervision and over the adult unit resultin	g staff provided adequate sight of patient activities on g in the failure to identify and n engaging in inappropriate ase refer to A-0395.					
	supervision, assessm for patients on the ad health unit. Please re	g staff provided adequate nent, and evaluation of care dult unit inpatient behavioral efer to A-0395.					

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		164006	B. WING				24/2023
	ROVIDER OR SUPPLIER EW BEHAVIORAL HEAL	тн		77	TREET ADDRESS, CITY, STATE, ZIP CODE 70 TANGLEFOOT LANE SETTENDORF, IA 52722		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		1	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY)			(X5) COMPLETION DATE
A 043	the adolescent unit reidentify and prevent pinappropriate sexual A-0395.	sight of patient activities on esulting in the failure to patients from engaging in behavior. Please refer to	A	043			
	4. Ensure the nursing staff provided adequate supervision, assessment, and evaluation of care for patients on the adolescent unit inpatient behavioral health unit. Please refer to A-0395. The cumulative effect of the systemic failure and deficient practices resulted in the hospital's inability to effectively carry out the responsibilities of the hospital to ensure patients received appropriate care and treatment in a safe setting and ensure quality health care provided to patients. The Hospital's administrative staff						
A 068	beginning of the surve CARE OF PATIENTS CARE CFR(s): 482.12(c)(4) [the governing bod following requirement A doctor of medicine for the care of each N to any medical or psy (i) Is present on administration; and (ii) Is not specifically of a doctor of dental services.	y must ensure that the ts are met:] or osteopathy is responsible Medicare patient with respect that ic problem that ission or develops during within the scope of practice surgery, dental medicine, optometry; a chiropractor; st, as that scope is	A	068			

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		164006	B. WING _			C 01/24/2023
	ROVIDER OR SUPPLIER	ALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 770 TANGLEFOOT LANE BETTENDORF, IA 52722	<u> </u>	01124/2023
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
A 068	(C) Limited, un section, with respect to the section of the section, with respect to the section of the sectio	ory State law; and der paragraph (c)(1)(v) of this ct to chiropractors. Is not met as evidenced by: Intreview, staff interviews, and review the Hospital called to ensure the hospital called the patient from copriate sexual behavior and content to the patient. The Hospital called the patient. The Hospital called the patient the beginning of spital Administrative Staff of 16 on the adolescent unit at	AO	68		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` '	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED		
		164006	B. WING			C 1/24/2023
	ROVIDER OR SUPPLIER EW BEHAVIORAL HEA	LTH		STREET ADDRESS, CITY, STATE, ZIP CODE 770 TANGLEFOOT LANE BETTENDORF, IA 52722	1	11/2-4/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
A 068	his sexually acting will plan. 2. Review of the pol Out Status" approve June 12th 2020, sta "The patient may be observation if deterracting out behavior." Patient #1, Patient #15-minute checks, will medical record indicacting out behavior. 3. During an interviet that Nurse B "did not Acting Out Precaution had training on preciting that when Patient #1 staff would separate Patient #1 would be patients. Then staff return Patient #1 be other patients again unit 500 and back of Administration would when we removed Fine When Patient #1 was acting out, staff tho	e chart, no documentation of vas included on the treatment vas included on the sunder Procedure, # 5. In placed on a higher level of onlined to be at risk for sexual vas vas vas done chart review of vas the tremained on every varied on every varied and escalation of sexually vas with Nurse B it was stated to the treatment vas varied vas vas varied vas varied vas vas varied vas varied vas	A 06	68		
	_	w with MHT D "knew this was entually. Patient #1 would act nim on 600 then				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER EW BEHAVIORAL HEAL	тн		STREET ADDRESS, CITY, STATE, ZIP CODE 770 TANGLEFOOT LANE BETTENDORF, IA 52722	1 01124/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
A 068	500 and Patient #1 h place". MHT D stated we are handling som 6. A review of the Po # 1 was arrested and View facility, for Patie charged with indecer intent to commit sex	make us bring him back to ad no extra precautions in d "I am concerned about how e of these situations". lice report revealed, Patient I removed from the Eagle ent # 3 and Patient #4 ht exposure, assault with abuse, and an additional d 3 of 3rd degree sexual	A 06	58	
A 115	a group session on the learned from patients that was crossing bo touching other patient identified as Patient identified as Patient idecussion Nurse E h #2 and confessed to touching other femalograbbing Patient # 5' wrapped arms aroun had attempted to get 7, both dressed. Patient bed by Patient #2, arbreast. PATIENT RIGHTS CFR(s): 482.13 A hospital must prote patient's rights. This CONDITION is The patient has the setting, see A-0144.	#2. After the group nad a discussion with Patient having inappropriately es. Specifics on this was	A 11	15	

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	ROVIDER OR SUPPLIER EW BEHAVIORAL HEAI			STREET ADDRESS, CITY, STATE, ZIP CODE 770 TANGLEFOOT LANE BETTENDORF, IA 52722		1/24/2023	
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A 115	patients have a right evidence of female passaulted. The hospital failed to patients received can	ve staff failed to ensure that to care in a safe setting by patients having been sexually ensure behavioral health re in a safe setting without	A 1	15			
A 144	A-0144. PATIENT RIGHTS: CCFR(s): 482.13(c)(2) The patient has the resetting. This STANDARD is During the investigation-site survey team	cother patients. Please see CARE IN SAFE SETTING right to receive care in a safe not met as evidenced by: tion of complaints and, the identified an Immediate on (a crisis situation that	A 14	14			
	placed the health an related to the Condit Rights (CFR 482.13) provide adequate nu oversight of patient at 1. While on-site, the	d safety of patients at risk) ion of Participation for Patient i. The hospital failed to rsing supervision and activities. survey team identified an					
	administrative staff of hospital staff acted a of the situation prior the complaint investi administrative staff to 2. Provided reeducation policy on Sexually Action 1.	(IJ) situation and notified the in 12/28/22 at 1:00 P.M. The ind removed the immediacy to the survey team exiting gation when the hospital book the following steps: tion of all staff on each of the cting Out Precautions r next scheduled shift.					
	3. Provided educatio	n to all RN's, MHT's, House					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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A 144	policies, staffing ex	e sexually acting out precaution	A 14	4			
		lition level deficiency remained Participation for Patient 2.13).					
	Based on document review, staff interviews, and video surveillance review the Hospital Administrative staff failed to ensure the hospital had adequate training on sexually acting precautions and level of observation with adequate supervision resulted in the nursing staff failing to identify and prevent patient from engaging in inappropriate sexual behavior and could potentially also result in self-harm, harm to others and death to the patient. The Hospital Administrative Staff identified a current census of 15 patients on the adult unit at the beginning of the survey. The Hospital Administrative Staff identified a census of 16 on the adolescent unit at the beginning of the survey.						
	Out Status" approv June 12th 2020, sta states "SAO precau Treatment Plan", a states "Treatment p documenting the pa made a for Patient treatment plan in the	olicy 1000.23, "Sexually Acting ed by the Governing Board on lates under Procedure, #4. Lations will be addressed on the late and #8. Documentation, a., lolan entry made and dated latients change in status" # 1, based on review late chart, no documentation of late was included on the treatment					

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	NAME OF PROVIDER OR SUPPLIER EAGLE VIEW BEHAVIORAL HEALTH			7	TREET ADDRESS, CITY, STATE, ZIP CODE 70 TANGLEFOOT LANE SETTENDORF, IA 52722	1 01/2	24/2023
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		1	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY)			(X5) COMPLETION DATE
A 144	Out Status" approved June 12th 2020, state "The patient may be posservation if determ acting out behavior.", Patient #1, Patient #15-minute checks, wheelical record indicated acting out behavior. 3. During an interview that when Patient #1 staff would separate Patient #1 would be patients. Then staff we return Patient #1 back on Administration would when we removed Pawhen Patient #1 was acting out, staff thous closely monitored or behavior was very inated. 4. During an interview going to happen ever out, staff would put his Administration would 500 and Patient #1 his place". MHT D stated we are handling some 5. A review of the Pol #1 was arrested and View facility, for Patient #1 patient #2 was arrested and View facility, for Patient #3.	by 1000.23, "Sexually Acting I by the Governing Board on a under Procedure, # 5. placed on a higher level of ined to be at risk for sexual based on chart review of 1 remained on every nen documentation in the sted an escalation of sexually with Nurse C, it was stated, was acting inappropriate, Patient #1 to unit 600, were separated from the other were told by administration to tok to unit 500 back around Patient #1 would return to 15 minute checks, "if have only listened to us, attent #1 from the unit to 600, an inappropriately sexually goth he should be more be isolated, Patient #1 appropriate". With MHT D "knew this was attually. Patient #1 would act and no extra precautions in 1"I am concerned about how are of these situations".	A	144			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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	тн		STREET ADDRESS, CITY, STATE, ZIP CODE 770 TANGLEFOOT LANE BETTENDORF, IA 52722	1 01124/2020	
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intent to commit sex charge with Patient # abuse. 6. During an interview	abuse, and an additional 3 of 3rd degree sexual v with Nurse E stated during	A 14	14		
learned from patients that was crossing bortouching other patient identified as Patient idescussion Nurse E h #2 and confessed to touching other female grabbing Patient # 55 wrapped arms arounhad attempted to get 7, both dressed. Patients	there has been a patient undaries and inappropriately ts. That patient was \$\frac{4}{2}\$. After the group and a discussion with Patient having inappropriately es. Specifics on this was s breast. Patient # 7 d Patient # 7's waist, and in the shower with Patient # ent #6 was pulled into the				
Rights, To Be Free st from mental, physica ". 8. A review of the Po # 1 was arrested and	ates 'have right to be free I, sexual and verbal abuse lice report revealed, Patient removed from the Eagle				
charged with indecer intent to commit sex charge with Patient # abuse. NURSING SERVICE CFR(s): 482.23 The hospital must has service that provides	at exposure, assault with abuse, and an additional 3 of 3rd degree sexual S ve an organized nursing 24-hour nursing services.	A 38	35		
	ROVIDER OR SUPPLIER EW BEHAVIORAL HEAL SUMMARY ST (EACH DEFICIENCE REGULATORY OR Continued From page intent to commit sex a charge with Patient # abuse. 6. During an interview a group session on th learned from patients that was crossing bot touching other patient identified as Patient # discussion Nurse E h #2 and confessed to touching other female grabbing Patient # 5's wrapped arms arounch had attempted to get 7, both dressed. Patie bed by Patient #2, ar breast. 7. A review of the Patien Rights, To Be Free st from mental, physica". 8. A review of the Pot # 1 was arrested and View facility, for Patie charged with indecer intent to commit sex a charge with Patient # abuse. NURSING SERVICE CFR(s): 482.23 The hospital must ha service that provides	TORRECTION TORROWIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 9 intent to commit sex abuse, and an additional charge with Patient #3 of 3rd degree sexual abuse. 6. During an interview with Nurse E stated during a group session on the adolescent unit Nurse E learned from patients there has been a patient that was crossing boundaries and inappropriately touching other patients. That patient was identified as Patient #2. After the group discussion Nurse E had a discussion with Patient #2 and confessed to having inappropriately touching other females. Specifics on this was grabbing Patient #5's breast. Patient #7 wrapped arms around Patient #7's waist, and had attempted to get in the shower with Patient #7, both dressed. Patient #6 was pulled into the bed by Patient #2, and grabbed Patient #6's breast. 7. A review of the Patient Handbook under Patient Rights, To Be Free states 'have right to be free from mental, physical, sexual and verbal abuse". 8. A review of the Police report revealed, Patient #1 was arrested and removed from the Eagle View facility, for Patient #3 and Patient #4 charged with indecent exposure, assault with intent to commit sex abuse, and an additional charge with Patient #3 of 3rd degree sexual abuse. NURSING SERVICES	TOURISH TOUR SUPPLIER THE BEHAVIORAL HEALTH SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 9 intent to commit sex abuse, and an additional charge with Patient #3 of 3rd degree sexual abuse. 6. During an interview with Nurse E stated during a group session on the adolescent unit Nurse E learned from patients there has been a patient that was crossing boundaries and inappropriately touching other patients. That patient was identified as Patient #2. After the group discussion Nurse E had a discussion with Patient #2 and confessed to having inappropriately touching other females. Specifics on this was grabbing Patient #5's breast. Patient #7 wrapped arms around Patient #7's waist, and had attempted to get in the shower with Patient #7, both dressed. Patient #6 was pulled into the bed by Patient #2, and grabbed Patient #6's breast. 7. A review of the Patient Handbook under Patient Rights, To Be Free states 'have right to be free from mental, physical, sexual and verbal abuse". 8. A review of the Police report revealed, Patient #1 was arrested and removed from the Eagle View facility, for Patient #3 and Patient #4 charged with indecent exposure, assault with intent to commit sex abuse, and an additional charge with Patient #3 of 3rd degree sexual abuse. NURSING SERVICES CFR(s): 482.23 The hospital must have an organized nursing service that provides 24-hour nursing services.	ROWIDER OR SUPPLIER EW BEHAVIORAL HEALTH SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR ISC IDENTIFYING INFORMATION) Continued From page 9 intent to commit sex abuse, and an additional charge with Patient #3 of 3rd degree sexual abuse. 6. During an interview with Nurse E stated during a group session on the adolescent unit Nurse E learned from patients there has been a patient that was crossing boundaries and inappropriately touching other patients. That patient was identified as Patient #2. After the group discussion Nurse E had a discussion with Patient #2 and confessed to having inappropriately touching other females. Specifics on this was grabbing Patient #5's breast. Patient #7 wasped arms around Patient #7 wasped arms around Patient #7 wasped arms around Patient #6's breast. 7. A review of the Patient Handbook under Patient Rights, To Be Free states 'have right to be free from mental, physical, sexual and verbal abuse. 7. A review of the Police report revealed, Patient #1 was arrested and removed from the Eagle View facility, for Patient #3 and Patient #4 charged with indecent exposure, assault with intent to commit sex abuse, and an additional charge with indecent exposure, assault with intent to commit sex abuse, and an additional charge with patient #3 of 3rd degree sexual abuse. NURSING SERVICES CFR(s): 482.23 The hospital must have an organized nursing service that provides 24-hour nursing services.	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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A 385	A 385 Continued From page 10 supervised by a registered nurse. This CONDITION is not met as evidenced by: 1. Ensure the nursing staff provided adequate supervision and oversight of patient activities on the child and adolescent unit. Please refer to A-0395. 2. Ensure the nursing staff provided adequate supervision, assessment, and evaluation of care to patients on the adult and adolescent units. Please refer to A-0395. The cumulative effect of these failures and deficient practices resulted in the hospital's inability to provide adequate patient care and supervision for adolescents, and adults, which resulted in adolescents and adults engaging in inappropriate sexual behaviors, and could		A	385			
A 395	potentially result in self-harm, harm to others and death to the patient. The hospital administrative staff identified a census of 31 patients on entrance.		Α:	395			

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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
A 395	could potentially also others and death to the Administrative Staff in 15 patients on the active survey. The Hospidentified a census of the beginning of the series in the beginning in the series in the beginning the pattern and a for Patient # treatment plan in the his sexually acting with plan. 2. Review of the policy out Status approved June 12th 2020, state "The patient may be observation if determacting out behavior." Patient #1, Patient #15-minute checks, with medical record indicated acting out behavior. 3. During an interview that Nurse B "did not Acting Out Precaution in the series in the	riate sexual behavior and result in self-harm, harm to he patient. The Hospital dentified a current census of fult unit at the beginning of bital Administrative Staff of 16 on the adolescent unit at survey. Exp 1000.23, "Sexually Acting the Board on t	A 3	95			

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NAME OF PROVIDER OR SUPPLIER EAGLE VIEW BEHAVIORAL HEALTH			1	7	TREET ADDRESS, CITY, STATE, ZIP CODE 70 TANGLEFOOT LANE BETTENDORF, IA 52722		
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A 395	that when Patient #1 staff would separate Patient # 1 would be patients. Then staff we return Patient # 1 bac other patients again, unit 500 and back on Administration would when we removed Pawhen Patient # 1 was acting out, staff thousely monitored or behavior was very ina 5. During an interview going to happen ever out, staff would put his Administration would 500 and Patient #1 haplace". MHT D stated we are handling some 6. During an interview a group session on the learned from patients that was crossing bot touching other patient identified as Patient # discussion Nurse E h #2 and confessed to touching other female grabbing Patient # 5's wrapped arms around had attempted to get 7, both dressed. Patie	with Nurse C, it was stated, was acting inappropriate, Patient #1 to unit 600, were separated from the other were told by administration to exist to unit 500 back around Patient #1 would return to 15 minute checks, "if have only listened to us, atient #1 from the unit to 600, atient #1 from the unit to 600, atient #1 from the unit to 600, atient #1 appropriately sexually ght he should be more be isolated, Patient #1 appropriate". With MHT D "knew this was attually. Patient #1 would act im on 600 then make us bring him back to ad no extra precautions in 1"I am concerned about how the of these situations". With Nurse E stated during the adolescent unit Nurse E there has been a patient undaries and inappropriately ts. That patient was \$2. After the group ad a discussion with Patient thaving inappropriately es. Specifics on this was	A	395			

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		164006	B. WING		C
NAME OF PRO	VIDER OR SUPPLIER	104000		STREET ADDRESS, CITY, STATE, ZIP CODE	01/24/2023
E401 E 1//EV	V DELLA VIODAL LIEAL:			770 TANGLEFOOT LANE	
EAGLE VIEV	V BEHAVIORAL HEAL	IH		BETTENDORF, IA 52722	
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE COMPLETION