DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IAPM015	A. BUILDING: _____ B. WING _____	C 05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	POC
FOUR OAKS SMITH CENTER-PMIC	5400 KIRKWOOD BOULEVARD SW CEDAR RAPIDS, IA 52404	7/13/2026

(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) COMPLETE DATE
A 000	Initial Comments Complaint investigations #130016-C and #132020-C, conducted from 5/4/2026 to 5/6/2026, resulted in Federal PRTF deficiencies cited at N0149, N0189, and N0214 and a PMIC deficiency cited at A0170.	A 000	The organization will: 1. Review current Level of Protection (LOP) Protocol related to suicide screening and interventions to ensure expectations are clearly defined.	7/13/26
A 170	41.10 Active Treatment 481-41.10(135H) Active treatment. Inpatient psychiatric services must involve "active treatment," which means implementation of a professionally developed and supervised individual plan of care as described in rule 481-41.12(135H). The plan of care shall be: 1. Developed and implemented no later than 14 days after admission; and 2. Designed to achieve discharge from inpatient status at the earliest possible time. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide support as directed by an individual plan of care. This affected 1 of 1 children's (Child 1) files reviewed in Complaints #130016-C and #132020-C. Findings follow: 1. Record review on 5/4/26 revealed the Child 1's Behavior Management Report #14642, dated 4/12/2026 at 4:20 p.m., indicated Child 1 attempted to strangle himself with a computer cord. Record review on 5/4/2026 revealed Child 1's individual plan of care, updated on 4/6/2026, documented Child 1's history of self-abusive	A 170	2. Reinforce staff education regarding suicide screening tools, documentation requirements, and initiation of precautions with the use of ongoing training processes. 3. Reinforce supervisory expectations for timely assessments, documentation, and implementation of suicide precautions. 4. Incorporate routine quality assurance review of records to ensure compliance with LOP protocol. Compliance will be monitored through ongoing supervisory review, compliance monitoring, and routine quality assurance audits conducted by program leaders and Quality and Compliance department. Monitoring will occur on a routine basis. Date of Correction: 7/13/26	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 170	Continued From page 1 behavior. Child 1's plan directed staff to place Child 1 on a Level of Protection (LOP) when Child 1 displayed self-abusive behavior or suicidal comments and actions. The facility's Level of Protection, dated 2/5/2026, documented any program staff or team member could start a LOP when a child demonstrated signs of self-harm or suicide. The policy directed facility staff used a screening tool to determine the level of risk of self-harm. Only a licensed clinician had the authority to end a LOP. Additional record review failed to indicate staff initiated a LOP. When interviewed on 5/6/2026 Child 1's therapist confirmed staff should have implemented a Level of Protection when Child 1 wrapped computer cords around his neck. 2. Record review on 5/7/2025, revealed Child 1's Level of Protection/Columbia-Suicide Severity Rating Scale form, dated from 3/17/2026 to 3/30/2026 indicated staff provided Child 1 heightened level of supervision which included bed checks every 5 minutes. Child 1's door remained open at all times. Child 1's bed check logs dated 3/17, 3/18, 3/20, 3/22, 3/23, 3/24, 3/25, 3/27, 3/28, 3/29 and 3/30/2026 documented staff completed bed checks every 15 minutes. Additional record review failed to reveal Child 1's bed check logs dated 3/19, 3/21 and 3/26/2026. The facility's Suicide and Self-Harm Level of Protection policy, dated 2/5/2026, directed when	A 170	The organization: 1. Completed a Level of Protection (LOP) protocol and related documentation review as it relates to frequency of observations and monitoring precautions. 2. Based on the review, determination was made to standardize monitoring expectations to occur at 15-minute intervals. 3. Updated all protocols and documentation tools to reflect this change. 4. Communicated to staff the updated expectations to ensure consistent implementation. Compliance with the revised LOP protocol is monitored through ongoing supervisory	7/13/26

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A 170	Continued From page 2 the child's plan indicated it within the plan, staff conducted bed checks every 5 minutes. When interviewed on 5/7/26 at 11:35 a.m. the Assistant Vice President of Residential and the Compliance Manager both confirmed staff failed to provide bed checks based on Child 1's identified needs.	A 170	oversight and routine quality assurance activities, including routine reviews of LOP documentation. Program leaders and the Quality and Compliance department are responsible for monitoring compliance and addressing concerns through additional education or corrective action as needed. Date of Correction: 7/13/26 The organization will: 1. Review incidents in which bed checks couldn't be located. 2. Review overnight practices and supervisory oversight processes to identify contributing factors. 3. Re-educate staff on expectations for timely and accurate bed check documentation and required observation intervals. 4. Enhance supervisory processes to verify completion of bed check documentation. Compliance is monitored through ongoing supervisory review of bed check documentation conducted by both program leadership and Quality and Compliance staff. Concerns are addressed through staff education, coaching, and corrective action when needed. Date of correction: 7/13/26	7/13/26

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N 000	Initial Comments Complaint investigations #130016-C and #132020-C, conducted from 5/4/2026 to 5/6/2026, resulted in Federal PRTF deficiencies cited at N0149, N0189, and N0214 and a PMIC deficiency cited at A0170.	N 000		
N 149	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(h) Staff must document the intervention in the resident's record. That documentation must be completed by the end of the shift in which the intervention occurs. If the intervention does not end during the shift in which it began, documentation must be completed during the shift in which it ends. Documentation must include all of the following: This ELEMENT is not met as evidenced by: Based on record review and interview, the facility failed to document restraints before the end of the shift. This affected 1 of 1 children (Child 1) in Complaints #130016-C and #132020-C. Findings include: Record review on 5/4/2026 revealed the following: Child 1's Behavior Management Report #14635, dated 4/12/2026, documented Child 1 attempted to intervene in a restraint involving another child in the unit. Staff A placed hands on Child 1 and directed Child 1 to the seclusion room at 12:08 p.m. Child 1's Behavior Management Report #14642,	N 149	The organization will: 1. Review policies related to behavior management and incident reporting to ensure clear definitions regarding restraints and other physical interventions. 2. Train staff on classification critiera for physical interventions. 3. Strengthen supervisory process to ensure timely and appropriate documentation of physical interventions occurs. Compliance is monitored through ongoing supervisory review and routine Quality and Compliance auditing. Monitoring includes review of incident and behavior management reports involving physical interventions to ensure accurate classification and appropriate documentation, with follow-up training provided as needed. Date of Correction: 7/13/26	7/13/26

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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.

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N 149	Continued From page 1	N 149		

dated 4/12/2026, documented Child 1 attempted to strangle himself using a computer cord. Staff A escorted Child 1 to the seclusion room at 4:20 p.m.

Child 1's Behavior Management Report #15017, dated 4/27/2026, documented Child 1 attempted to hit Staff A. Staff A placed Child 1 into the seclusion room at 9:10 p.m.

Record review on 5/5/2026 revealed facility surveillance video dated 4/12/2026 at 12:08 p.m., showed Staff A physically redirected another child. Child 1 chased after Staff A. Both disappeared off camera. When they moved back into camera view, Staff A stood behind Child 1. Staff A grasped Child 1's right wrist with his right hand and wrapped his left hand over Child 1's forearm just inside the elbow. Staff A secured Child 1's forearm against Child 1's waist as he was escorted to the seclusion room.

The facility surveillance video dated 4/12/2026 at 4:20 p.m., showed Child 1 placed a computer cord around his neck in Pod 2. Staff A watched Child 1 through the doorway. Child 1 attempted to grab additional computer cords. Staff A placed his right arm under Child 1's arm and his left arm high across Child 1's chest and abruptly pulled Child 1 off balance. This maneuver caused Child 1 to fall to the floor, where Staff A removed the computer cord from Child 1's neck. Staff A grabbed Child 1's right wrist, pulled him to his feet, grasped Child 1's left wrist with his left hand, and wrapped his right hand over Child 1's forearm just inside the elbow to keep Child 1's forearm secured against his waist as he escorted him to seclusion.

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N 149	Continued From page 2	N 149		

The facility surveillance video dated 4/27/2026 at 9:10 p.m., audibly recorded, Staff A argued with Child 1 about keeping his light off. Staff B entered Pod 2 and directed Staff A to disengage from Child 1. Staff A verbally threatened Child 1. Staff B placed themselves between Staff A and Child 1. Staff A stepped back from Child 1's doorway, moving back into full view of the Pod 2 camera. Staff A stepped back and called Child 1 an [explicit]. Child 1 appeared on the Pod 2 camera, carrying a black pedestal floor fan, and attempted to strike Staff A. Staff C joined Staff B, and both staff members used body positioning to keep Child 1 from reaching Staff A. They stood on either side of Child 1, grasped him around the waist, and placed their hands on Child 1's opposite hip bone area and prevented movement. After approximately 5 to 10 seconds, Child 1 gained a release and approached Staff A in the main area of the unit. Staff A placed his left arm high across Child 1's chest/neck area, and placed his right hand under Child 1's right armpit while facing away from the seclusion room, and walked backwards toward the seclusion room. Child 1's left foot left the floor. He appeared to be off-balance enough to have landed on his back or his head/neck area.

Continued record review failed to reveal documentation of the restraints.

Additional record review revealed the facility's Behavior Management Policy dated 11/20/2025, indicated the use of physical restraint would be documented and placed in the individual's record.

When interviewed on 5/7/2026 at 10:50 a.m., the Quality Compliance Manager and the Assistant Vice President of Residential Services confirmed

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N 149	Continued From page 3 staff should have documented these restraints on Behavior Management Reports.	N 149		
N 189	POST INTERVENTION DEBRIEFINGS CFR(s): 483.370(b) Within 24 hours after the use of restraint or seclusion, all staff involved in the emergency safety intervention, and appropriate supervisory and administrative staff, must conduct a debriefing session that includes, at a minimum, a review and discussion of - 483.370(b)(1) The emergency safety situation that required the intervention, including discussion of the precipitating factors that led up to the intervention; This ELEMENT is not met as evidenced by: Based on record review and interview, the facility failed to include supervisory and administrative personal in a debriefing session. This occurred in 1 of 3 interventions reviewed for Child 1 in Complaints #130016-C and #132020-C. Findings include: Record review on 5/4/2026 revealed Child 1's Behavior Management Report #15017 dated 4/27/2026, documented Staff A placed Child 1 in seclusion from 9:10 p.m. to 9:20 p.m. The staff debriefing took place at 10:00 p.m. The staff debriefing included all 3 staff members involved in the emergency safety intervention. Additional record review failed to reveal a supervisor or administrator participated in the debriefing.	N 189	The organization will: 1. Review debriefing expectations with staff to ensure compliance with policy for completion within 24 hours and inclusion of all required participants including supervisory or administrative personnel. 2. Review documentation tools to ensure participant information is consistently captured and reflected in records. Compliance is monitored through ongoing supervisory review of debriefing documentation and routine quality assurance audits conducted by program leadership and the Quality and Compliance department. Monitoring includes verification that required debriefings are completed timely and that they include documentation of required participants. Date of Correction: 7/13/26	7/13/26

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N 189	Continued From page 4 Record review revealed the facility's Behavior Management Policy, dated 11/20/2025, indicated supervisory personnel participated in the debriefing. When interviewed on 5/7/2026 at 10:50 a.m., the Quality Compliance Manager and the Vice President of Residential Services confirmed a supervisor or administrator should have been included on Behavior Management Report #15017.	N 189		
N 214	EDUCATION AND TRAINING CFR(s): 483.376(a) The facility must require staff to have ongoing education, training, and demonstrated knowledge of - This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure staff recognized when a restraint occurred prior to a seclusion. This affected 3 of 3 staff (Staff A, Staff B and Staff C) in Complaints #132016-C and #132020-C. Findings include: Record review on 5/5/2026 revealed facility surveillance video dated 4/12/2026 at 12:08 p.m., showed Staff A physically redirected another child. Child 1 chased after Staff A. Both disappeared off camera, when they moved back into camera view, Staff A stood behind Child 1. Staff A grasped Child 1's right wrist with his right hand and wrapped his left hand over Child 1's forearm just inside the elbow. Staff A secured Child 1's forearm against Child 1's waist as he was escorted to the seclusion room.	N 214	The organization will: 1. Review Behavior Management and Incident Reporting policies to ensure clear definitions and requirements for identification, documentation, and authorization of restraint events as well as requirements for timely authorization and documentation. 2. Provide staff education to ensure recognition of restraint events and understanding of associated requirements for timely authorization and documentation. 3. Strengthen supervisory process to ensure appropriate identification of restraints, completion of authorization procedure, and documentation occurs. Compliance is monitored through ongoing supervisory oversight and routine quality assurance auditing by program leadership and Quality and Compliance department. Monitoring includes review of behavior	7/13/26

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N 214	Continued From page 5 The facility surveillance video dated 4/12/2026 at 4:20 p.m., showed Child 1 placed a computer cord around his neck in Pod 2. Staff A watched Child 1 through the doorway. Child 1 attempted to grab additional computer cords, Staff A placed his right arm under Child 1's arm and his left arm high across Child 1's chest and abruptly pulled Child 1 off balance. This maneuver caused Child 1 to fall to the floor, where Staff A removed the computer cord from Child 1's neck. Staff A grabbed Child 1's right wrist, pulled him to his feet, grasped Child 1's left wrist with his left hand, and wrapped his right hand over Child 1's forearm just inside the elbow to keep Child 1's forearm secured against his waist as he escorted him to seclusion. The facility surveillance video dated 4/27/2026 at 9:10 p.m., audibly recorded, Staff A argued with Child 1 about keeping his light off. Staff B entered Pod 2 and directed Staff A to disengage from Child 1. Staff A verbally threatened Child 1. Staff B placed themselves between Staff A and Child 1. Staff A stepped back from Child 1's doorway, moving back into full view of the Pod 2 camera. Staff A stepped back and called Child 1 an [explicit]. Child 1 appeared on the Pod 2 camera, carrying a black pedestal floor fan and attempted to strike Staff A. Staff C joined Staff B, and both staff members used body positioning to keep Child 1 from reaching Staff A. They stood on either side of Child 1, grasped him around the waist, and placed their hands on Child 1's opposite hip bone area and prevented movement. After approximately 5 to 10 seconds Child 1 gained a release and approached Staff A in the main area of the unit. Staff A placed his left arm high across Child 1's chest/neck area, and placed	N 214	management incidents to ensure appropriate classification, documentation, and authorization occurs in accordance with policy. Additional education and corrective action are implemented as needed based on findings. Date of Correction: 7/13/26	

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N 214	Continued From page 6 his right hand under Child 1's right armpit while facing away from the seclusion room, and walked backwards toward the seclusion room. Child 1's left foot left the floor. He appeared to be off-balance enough to have landed on his back or his head/neck area. Additional record review failed to reveal restraint documentation. Record review revealed the facility's Behavior Management Policy, dated 11/20/2025, indicated staff obtained authorization when restraint was needed. When interviewed, on 5/11/2026 at 5:50 p.m. the Assistant Vice President of Residential Services confirmed Staff physically prevented Child 1's ability to move. She explained Staff A may have thought he used escort techniques. She acknowledged staff restrained Child 1 and staff failed to obtain appropriate restraint authorizations.	N 214		