STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 16L007	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR OAKS MCINTYRE CENTER-PMIC	**5400 KIRKWOOD BOULEVARD SW , CEDAR RAPIDS, Iowa, 52404**

(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
E0000	Initial Comments The following deficiencies were cited during the review of the Federal PRTF certification rules for Psychiatric Residential Treatment Facilities (Appendix Z).	E0000		
N0000	Initial Comments The following deficiencies were cited during the review of the Federal PRTF certification rules for Psychiatric Residential Treatment Facilities (Appendix N).	N0000		
E0030	Names and Contact Information CFR(s): 441.184(c)(1) §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.542(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at	E0030		

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 reverse for further 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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E0030	Continued from page 1 §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians.	E0030		

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E0030	Continued from page 2 (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This STANDARD is NOT MET as evidenced by: Based on document review and interviews, the facility failed to update the emergency preparedness plan (EPP) contact list when Program Shift Leaders ended their employment within the McIntyre Unit. This affected 1 of 3 Program Shift Leaders listed on the communication plan. Findings follow: Record review on 8/11/2026 revealed the facility's EPP communication plan, last updated 3/2025, listed Staff A as the Program Coordinator for the McIntyre Center, but was no longer employed by the facility. When interviewed via email on 8/12/2026 with the facility's Human Resources Department documented Staff's employment with the facility ended on 7/1/2025. When interviewed on 8/11/2026 at 9:20 a.m., the Quality and Compliance Manager confirmed these findings.	E0030		

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E0037	EP Training Program CFR(s): 441.184(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to	E0037		

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E0037	Continued from page 4 protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must	E0037		

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E0037	Continued from page 5 conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where	E0037		

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E0037	Continued from page 6 necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This STANDARD is NOT MET as evidenced by: Based on record review and interviews, the facility failed to train new staff members in the Emergency Preparedness Plan (EPP). This affected 3 of 3 staff members reviewed. Findings follow: Record review on 8/12/2026 revealed the facility's New Hire Orientation Checklist included initial EPP training. Staff C's personnel file documented the facility hired Staff C on 2/20/2026.Staff C's RELIAS training record and Staff Onboarding Check Sheets failed to reveal documentation of initial training on EPP. Staff D's personnel file documented the facility hired Staff D on 5/11/2026.Staff D's RELIAS training record and Staff Onboarding Check Sheets failed to reveal documentation of initial training on EPP. Staff E's personnel file documented the facility hired Staff E on 8/12/2026.Staff E's RELIAS training record and Staff Onboarding Check Sheets failed to reveal documentation of initial training on EPP. Additional record review revealed the facility's EPP policy, updated 3/2025, indicated the facility's employees were trained to fulfill the duties relevant to their	E0037		

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E0037	Continued from page 7 particular job descriptions when emergencies arose within their assigned program. When interviewed on 8/12/2026 at 3:15 p.m., the Training and Development Director confirmed three staff members reviewed had not received initial training in EPP.	E0037		
N0143	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(d) If the order for restraint or seclusion is verbal, the verbal order must be received by a registered nurse or other licensed staff such as a licensed practical nurse, while the emergency safety intervention is being initiated by staff or immediately after the emergency safety situation ends. The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must verify the verbal order in a signed written form in the resident's record. The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must be available to staff for consultation, at least by telephone, throughout the period of the emergency safety intervention. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the facility failed to ensure a verbal order for an emergency safety intervention (ESI) was obtained timely. This affected 1 of 3 sample children (Child 1). Findings include: Record review on 8/11/2025 revealed Child 1's Behavior Management Report (BMR) dated 6/8/2026, indicated staff restrained Child 1 from 1:23 p.m. to 1:25 p.m. Further review failed to reveal an authorization signature and indicated staff members had not notified health services of the restraint until 6:10 p.m. Record review on 8/11/2026 revealed the Four Oaks 2026 Behavior Management Policy, revised 5/1/2026, indicated the use of physical restraint should be authorized by a qualified staff member who possessed appropriate credentials, knowledge, and expertise, and in accordance with federal or state requirements, and documented on the BMR. When interviewed on 8/11/2026 at 2:25 p.m., Nurse A confirmed staff members failed to seek authorization for the restraint documented in Child 1's BMR until 6:10 p.m.	N0143		
N0145	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(f)	N0145		

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N0145	Continued from page 8 Within 1 hour of the initiation of the emergency safety intervention a physician, or other licensed practitioner trained in the use of emergency safety interventions and permitted by the state and the facility to assess the physical and psychological wellbeing of residents, must conduct a face-to-face assessment of the physical and psychological wellbeing of the resident, including but not limited to- (1) The resident's physical and psychological status; (2) The resident's behavior; (3) The appropriateness of the intervention measures; and (4) Any complications resulting from the intervention. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the facility failed to ensure a post-restraint assessment was conducted within 1 hour of the initiation of the ESI. This affected 1 of 6 sample children (Child 1). Findings include: Record review on 8/11/2025 revealed Child 1's Behavior Management Report (BMR) dated 6/8/2026 indicated staff restrained Child 1 from 1:23 p.m. to 1:25 p.m. Further review failed to reveal an authorization signature and indicated staff members had not notified health services of the restraint until 6:10 p.m. Record review on 8/11/2026 revealed the Four Oaks 2026 Behavior Management Policy, revised 5/1/2026, indicated the licensed authorizer conducted the physical assessment within 1 hour post-restraint. When interviewed on 8/11/2026 at 2:25 p.m., Nurse A confirmed staff members failed to seek authorization when they restrained Child 1 until 6:10 p.m., and the post-restraint assessment was not conducted until 6:15 p.m.	N0145		
N0222	EDUCATION AND TRAINING CFR(s): 483.376(f) Staff must demonstrate their competencies as specified in paragraph (a) of this section on a semiannual basis and their competencies as specified in paragraph (b) of this section on an annual basis.	N0222		

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N0222	Continued from page 9 This ELEMENT is NOT MET as evidenced by: Based on record review and interviews, the facility failed to ensure staff members demonstrated competency in restraint on a semiannual basis. This affected 2 of 17 staff members (Staff F and Staff G) involved in emergency safety interventions (ESI) reviewed. Findings follow: 1. Record review on 8/10/2026 revealed Child 2's Behavior Management Report (BMR) dated 7/14/2026 documented Staff F participated in the seclusion of Child 2 from 10:47 a.m. to 11:07 a.m. Record Review on 8/11/2026 revealed Four Oaks RELIAS staff training transcripts indicated the facility certified Staff F in the Mandt System (crisis intervention training) on 7/9/2025. Documentation of a skills refresher at the required six-month interval could not be provided. 2. Record review on 8/10/2026 revealed Child 3's Behavior Management Report (BMR) dated 7/14/2026 documented Staff G participated in the seclusion of Child 3 from 1:21 a.m. to 1:32 a.m. Record Review on 8/11/2026 revealed Four Oaks RELIAS staff training transcripts indicated the facility certified Staff G in the Mandt System on 1/26/2025. Documentation of a skills refresher at the required six-month interval could not be provided. Record review on 8/11/2026 revealed the facility's Behavior Management Policy, updated 5/1/2026, indicated the facility provided staff members initial Mandt training within the first 60 days of employment, and annual recertification of the Behavior Management program Training. Additionally, staff demonstrated physical intervention skill competency every six months. When interviewed on 8/11/2026 at 4:10 p.m., the Quality and Compliance Manager confirmed staff had not been up to date on restraint trainings.	N0222		

Iowa Department of Inspections, Appeals, and Licensing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 57PM33	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/13/2026

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A0000	Initial Comments No deficiencies were cited during the PMIC survey to determine compliance with Chapter 41 PMIC rules.	A0000		

Office of Primary Care and Health Systems Management

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