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
	97PM12	A. BUILDING: _____ B. WING _____	C 11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYS & GIRLS HOME & FAMILY SERV INC-BRICK	2101 COURT STREET, 6TH FLOOR - C SIOUX CITY, IA 51102

POC
1/13/2026

(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 A PMIC licensing review and investigations 130839-C and 130765-C were conducted from 11/17/2025 to 11/20/2025. The license review to determine compliance with Chapter 41 PMIC rules resulted in a deficiency cited at 41.11(3). Investigation #130839-C resulted in deficiences cited at N0170 and N0188. Investigation #130765-C resulted in no deficiencies cited.	A 000		
A 215	41.11(3)a, b Individual Plan of Care 41.11(3) The plan of care shall be reviewed every 30 days by the team referred to in rule 481-41.13(135H) to: a. Determine that services being provided are or were required on an inpatient basis; and b . Recommend changes in the plan as indicated by the recipient's overall adjustment as an inpatient. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to review the plan of care for 1 of 3 residents reviewed (Child 1). Findings included: Record review on 11/17/2025 revealed Child 1's resident case file indicated an admission date of 8/22/2025. The care plan was developed on 8/25/2025, and the 30-day review was completed on 9/20/2025. The subsequent review was conducted on 11/13/2025, 24 days beyond the 30-day review period.	A 215	Training Client Chart review completed Sample chart review monthly. See attached form What measure will be put into place for systemic changed made to ensure that the deficient practice will not recur: Supervision Due date of reviews are programmed into electronic medical record system. The electronic medical record system automates reports to Supervisor and Program Director of reports coming How will the corrective action be monitored to ensure that the deficient practice is being corrected and will not recur: Corrective Action will be reviewed by Supervisor and Program Director.	1/13/2026 12/19/2026. Ongoing

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

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

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A 215	Continued From page 1 This finding was confirmed by the Continuous Quality Improvement Assistant on 11/20/2025.	A 215	Person(s) who will be responsible for monitoring and ensuring that compliance is achieved and continues: Program Director, Chief Operating Officer.	

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N 170	MONITORING DURING AND AFTER SECLUSION CFR(s): 483.364(a) Clinical staff, trained in the use of emergency safety interventions, must be Physically present in or immediately outside the seclusion room, continually assessing, monitoring, and evaluating the physical and psychological well-being of the resident in seclusion. Video monitoring does not meet this requirement. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to adequately monitor children while in seclusion. This affected one of 14 control room stays reviewed from August and September 2025 in investigation # 130839-C. Finding follows: Record review on 11/17/2025 revealed Child 1's emergency safety intervention progress report dated 8/22/2025, indicated staff placed Child 1 in the control room at 4:43 pm. Staff documented his well-being at 5:00; however, the next checks were completed at 5:16, 5:32, 5:47 and 5:52 when he was released from the control room. Documentation of additional checks could not be located. The facility's Emergency Safety Intervention Policy dated 10/10/2023, indicated a trained staff member would be assigned to visually monitor the client continually during the entire intervention and observations would be documented in increments of every 5 minutes. When interviewed on 11/20/2025 at 5:00 pm the Chief Operating Officer and the Program Director confirmed staff failed to document checks as required.	N 170	What measures will be put into place for systematic change. Supervision training completion and documentation. Training by Program Director, Program Manager, Certified Emergency Intervention curriculum trainers. How will the corrective action be monitored to ensure that the deficient practice is being corrected adn will not reoccur: Corrective action will be reviewed by Program Director, Program Manager, and in supervision. Person(s) who will be responsible for monitoring and ensuring the compliance is achieved and continues. Program Director and Program Manager. How the corrective action will be accomplished: Emergency Intervention Review Form Implemented. Emergency Intervention Committee weekly. Members include Program Director, Program Manager and CQI Specialist.	1/12/26 1/12/26 1/12/26

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | 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.

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N 188	POST INTERVENTION DEBRIEFINGS CFR(s): 483.370(a) Within 24 hours after the use of the restraint or seclusion, staff involved in an emergency safety intervention and the resident must have a face-to-face discussion. This discussion must include all staff involved in the intervention except when the presence of a particular staff person may jeopardize the wellbeing of the resident. Other staff and the resident's parent(s) or legal guardian(s) may participate in the discussion when it is deemed appropriate by the facility. The facility must conduct such discussion in a language that is understood by the resident and by the resident's parent(s) or legal guardian(s). The discussion must provide both the resident and staff the opportunity to discuss the circumstances resulting in the use of restraint or seclusion and strategies to be used by the staff, the resident, or others that could prevent the future use of restraint or seclusion. This STANDARD is not met as evidenced by: Based on record review and interviews, facility staff did not conduct a thorough post-intervention debriefing following a control room stay. This affected one of 14 control room stays reviewed from August and September 2025 in investigation #130839-C. Finding follows: Record review on 11/17/2025 revealed Child 1's emergency safety intervention assessment dated 8/22/2025, documented the control room was utilized. The debriefing failed to include the child, and failed to indicate if staff, other staff, parents, or legal guardians participated in the debriefing. Documentation of any discussion regarding the circumstances that led to the use of seclusion or	N 188	What measures will be put into place for systems change Supervision Training completion and documentation Training by Program Director, Program Manager, certified Emergency Intervention curriculum trainers. How will corrective be monitored to ensure that the deficient practices is being corrected and will not reoccur: Corrective action will be reviewed by Program Director, Program Manager and in supervision. Person(s) who will be responsible for monitoring and ensuring that compliance is achieved and continues. Program Director and Program Manager. How the corrective action will be accomplished: Emergency Safety Intervention Review Form implemented. Emergency Safety Intervention Committee weekly. Members include Program Director, Program Manage and CQI Specialist. Ongoing Emergency Safety Intervention Training: Initial 6 month Yearly Form 170 attached	1/12/26 1/12/26 1/13/26

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N 188	Continued From page 2 strategies that could prevent future use of seclusion could not be located. The facility's Emergency Safety Intervention Policy, reviewed 10/10/2023, stated a debriefing with the client and staff involved be held and documented within 24 hours. This debriefing must include a discussion of the circumstances resulting in the use of the intervention, strategies to use in the future to prevent use of the intervention, and any need to update the client's treatment plan. Documentation would include the names of all staff present. Staff attendance was mandatory unless their presence agitates the client. Client's parents shall be invited to share thoughts regarding the intervention at the time the nurse notifies them of the incident. When interviewed on 11/20/25 at 4:00 pm the Chief Operating Officer and Program Director confirmed staff failed to conduct a debriefing as required.	N 188		