STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16L022	A. BUILDING _____ B. WING _____	C 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHILDREN'S SQUARE- FRIENDS AND FOUNDATION - COTT 1	619 CURTIS STREET CO BLUFFS, IA 51502

POC 8/13/25

(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
N 000	Initial Comments Investigation 129830-C and 129665-C were conducted from 7/7/2025 to 7/9/2025. The following deficiencies were cited during the complaint investigation to determine compliance with Psychiatric Residential Treatment Facilities rules (appendix N).	N 000	The Leadership team as referenced below is comprised of the Director of PMIC, Director of Behavioral Health Services, Senior Director of Residential Services, and the interim CEO. Upon review of this incident, the Leadership team in conjunction with the HR manager and the Quality and Special Projects Manager acknowledged that this incident is inappropriate; the youth was not at imminent risk; and there was no proper documentation of the incident. The following steps have been taken to ensure the protection of residents and proper documentation:	
N 128	PROTECTION OF RESIDENTS CFR(s): 483.356(a)(3) Restraint or seclusion must not result in harm or injury to the resident and must be used only- This ELEMENT is not met as evidenced by: Based on interview and record review the facility failed to prevent injury to Child 1 during a physical restraint. This affected 1 of 2 children (Child 1) in investigation #129830-C and #129665-C. Finding follows: Record review on 7/8/2025 revealed the Non-Violent Crisis Intervention documented on 5/4/2025 staff physically redirected Child 1 and then Staff A, Staff B and Staff C placed Child 1 in an emergency supine position restraint. During the restraint, Child 1 yelled her arm was hurt and she could not feel her hands. The Nursing Physical Intervention Monitoring and Follow-Up Assessment documented Child 1 had bilateral bruising on the upper arm. Record review on 7/8/2025 revealed the Child Abuse Assessments 2025126220, 2025126224 and 2025126225 documented Child 1 sustained extensive bruising on both upper extremities, including the upper arms, forearms, and shoulders. The bruises varied in size, shape and	N 128	• Staff were retrained in de-escalation techniques on 06/18/2025 during the regularly scheduled Big Team meeting. • A Mandatory Staff Training was held the week of 07/14/2025 to 07/18/2025 which focused again on de-escalation, CPI, and trauma-informed care. • Staff who were involved in this incident were immediately suspended to protect the children/youth in the program and then subsequently terminated due to not following proper de-escalation, CPI, and trauma-informed procedures. • All new YSS staff have been certified in CPI as of 7/18/2025 and existing YSS staff have been retrained and recertified in CPI. All YSS received an intensive one-day training on the impact of Trauma through our Certified Risking Connections trainer. Upon learning of this incident, the Leadership recognized the need to re-train staff on the procedures to be used to address behavior with children and youth. In addition to the training, Leadership has increased supervision of staff and conducted performance reviews to ensure there is proper documentation of coaching with staff and disciplinary actions if applicable.	06/18/2025 07/18/2025 05/07/2025 05/26/2025 07/18/2025 07/18/2025 08/01/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16L022	A. BUILDING _____ B. WING _____	C 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHILDREN'S SQUARE- FRIENDS AND FOUNDATION - COTT 1	619 CURTIS STREET CO BLUFFS, IA 51502

(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
N 128	Continued From page 1 coloration. Some of the bruises were dark purple or bluish hued while others were yellowish-green. Bruises were present anteriorly and posteriorly on the shoulders and arms with some clustered in areas. There were both round and irregular-shaped marks, some of which were linear or finger-like in pattern. Record review on 7/8/2025 revealed the Physical Intervention Procedure (reviewed 1/2021) stated Physical intervention could be used if there was an immediate danger of harm to self or others. Record review on 7/8/2025 revealed the Elopement Full Procedure implemented on 2/19/2025 stated youth under the age of 13 who displayed behaviors indicating an imminent attempt to elope would require physical intervention to prevent elopement. Physical intervention would only be used as a last resort when all other de escalation techniques had failed, and the safety of the youth or others was at risk. The procedure did not address the use of physical intervention to prevent elopement of children over the age of 13. Child 1 was 16 years old on 5/4/2025. When interviewed on 7/7/2025 at 10:25 am, the Interim Chief Executive Officer and the Chief Human Resource Director revealed Staff A, Staff B and Staff C's actions did not align with Children's Square's procedures and appropriate disciplinary action was taken. were terminated from their positions at Children ' s Square on 5/13/2025 due to their involvement in this restraint and subsequent injury of Child 1 as their actions did not align with Children ' s Square ' s procedures.	N 128	The Leadership team has reviewed the Supervision Status procedure and has made adjustments to the procedure to ensure safety while allowing for the practical functioning of the program. The revised policies are attached. • The updated Runaway/Elopement Youth Immediate Response Plan was enacted on 07/21/2025 and clarifies specific procedures in the use of physical intervention to prevent elopement of youth over the age of 13. The elopement procedures were renamed as “Runaway” procedures and will be referred to as such in this action. • Standard Operating Procedures for youth’s Supervision Status, Runaway Youth Risk Assessment, Runaway Youth Return, Runaway Youth Immediate Response Plan, and Runaway Youth Full Procedure were all updated and enacted on 07/21/2025. Staff were trained on the updated procedures during the Mandatory Staff Training held 07/14/2025-07/18/2025. • Change of Supervision Status and de-escalation efforts will be clearly documented in the youth’s EHR file.	07/21/2025 07/21/2025 07/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16L022	A. BUILDING _____ B. WING _____	C 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHILDREN'S SQUARE- FRIENDS AND FOUNDATION - COTT 1	**619 CURTIS STREET CO BLUFFS, IA 51502**

(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
N 132 N 132	Continued From page 2 PROTECTION OF RESIDENTS CFR(s): 483.356(b) Emergency safety intervention. An emergency safety intervention must be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the resident's chronological and developmental age; size; gender; physical, medical, and psychiatric condition; and personal history (including any history of physical or sexual abuse). This ELEMENT is not met as evidenced by: Based on interview and record review, the facility failed to perform an emergency safety intervention that was appropriate to the severity of the behavior. This affected 2 of 2 children (Child 1 and Child 2) in investigation #129830-C and 129665-C. Finding follows: 1. Record review on 7/8/2025 revealed the Non-Violent Crisis Intervention of Child 1 on 5/4/2025 documented Child 1 was in an area enclosed by a fence. Staff physically redirected Child 1 and then Staff A, Staff B and Staff C placed her in an emergency supine position restraint. This restraint was documented to be necessary due to Child 1 displaying run behaviors. Staff physically redirected Child 1 and she dropped to the ground. Staff then placed her in an emergency supine position with Staff C on her left arm, Staff B on her right arm and Staff A on her legs. The Nursing Physical Intervention Monitoring and Follow-Up Assessment documented Child 1 was hitting staff; however, the Non-Violent Crisis Intervention form indicated this occurred only after the physical intervention	N 132 N 132	Upon review of this incident, the Leadership team in conjunction with the HR manager and the Quality and Special Projects Manager acknowledge that this incident is inappropriate; the youth was not at imminent risk; and there was not proper documentation of the incident. The following steps have been taken to ensure the protection of residents and proper documentation: • Staff were retrained in de-escalation techniques on 06/18/2025 during the regularly scheduled Big Team meeting. • A Mandatory Staff Training was held the week of 07/14/2025 to 07/18/2025 which focused again on de-escalation, CPI, and trauma-informed care. • De-escalation training focused on using verbal de-escalation techniques and physical redirection was also a focus of the training delivered. • Staff involved in this incident were immediately suspended to protect the children/youth in the program and then subsequently terminated due to not following proper de-escalation, CPI, and trauma-informed procedures. • All new YSS staff have been certified in CPI as of 7/18/2025 and existing YSS staff have been retrained and recertified in CPI. All YSS received an intensive one-day training on the impact of Trauma through our Certified Risking Connections trainer. Upon learning of this incident, the Leadership recognized the need to re-train staff on the procedures to be used to address behavior with children and youth. In addition to the training, Leadership has increased supervision of staff and conducted performance reviews to ensure	06/18/2025 07/18/2025 07/18/2025 05/07/2025-05/26/2025 07/18/2025 08/01/2025

			there is proper documentation of coaching with staff and disciplinary actions if applicable.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16L022	A. BUILDING _____ B. WING _____	C 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHILDREN'S SQUARE- FRIENDS AND FOUNDATION - COTT 1	619 CURTIS STREET CO BLUFFS, IA 51502

(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
N 132	Continued From page 3 had been implemented and Child 1 expressed staff was hurting her. A physical intervention once Child 1 placed herself on the ground seemed unnecessary to prevent her from running out of a gated area of the facility. The intervention did not seem proportionate to the behavior. 2. Record review on 7/8/2025 revealed the Non-Violent Crisis Intervention documented Child 2 refused to get out of bed on the morning of 5/17/2025. Child 2 reacted violently to music being played, biting and scratching as well as attempting to punch staff. Staff then physically redirected Child 2 out of her room. Facility Video of the incident showed staff removed Child 2 from her room with physical force of their hands. Staff then used their legs against Child 2 in an attempt to move her as she remained seated on the floor. Staff D lifted Child 2 by her upper body and moved her to the common area of the cottage. Staff D and Staff E pulled Child 2's legs forward using a pulling motion on two separate occasions. When interviewed on 7/9/25 at 10:00 am, Child 2 stated she disclosed that staff pulled the mattress off of her bed, with her on it, when she refused to get out of bed. Child 2 also explained that the staff used their legs to push against her in an attempt to get her to stand and when she refused, they pulled her out of her room and into the commons. Child 2 said she had just started occupational therapy on 7/8/2025 to work on her issues with showering. When interviewed on 7/8/25 at 3:52 pm, Staff D reported Staff F slid the mattress off the bedframe while Child 2 was still lying on it.	N 132	• Leadership will revise a process to monitor and ensure compliance with incident reporting and debriefing procedures. This will include: 1. Reports are completed within 24 hours of the incident. 07/31/2025 2. Details of the incident are consistent across incident report platforms such as the incident report form, Non-Violent Crisis Intervention Form, and reviewed video. 08/13/2025 3. The Non-Violent Crisis Intervention Form is entered in the client profile. 07/31/2025 4. Debriefing will occur for all incidents to include who was present for the debriefing, the date and time of the debriefing, details of the debriefing, and any changes to the youth's treatment plan. 08/13/2025 5. YSS Staff will receive retraining on debriefing procedures including proper documentation at the Big Team meeting. 08/13/2025 6. The Quality and Special Projects Manager and YSS supervisor will monitor and track compliance procedures and documentation and will inform the Leadership team of their findings. 07/31/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16L022	A. BUILDING _____ B. WING _____	C 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHILDREN'S SQUARE- FRIENDS AND FOUNDATION - COTT 1	619 CURTIS STREET CO BLUFFS, IA 51502

(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
N 132	Continued From page 4 Record review on 7/9/2025 revealed Child 2's Plan of Care documented her history of being difficult to awaken and shower. Child 2 was admitted to the facility on 12/23/2024. Child 2's February and March 2025 Monthly Treatment Plan Review stated she would begin occupational therapy regarding hygiene the following week. Child 2's Quarterly review dated 3/23/2025 documented staff would work with Child 2 on hygiene and incorporate a hygiene chart with a reward system. A plan to address Child 1's ongoing refusals could not be located. Record review on 7/9/2025 of Child 2's MCO Authorization Interdisciplinary Team call on 2/20/2025 discussed Child 2 had to be prompted continuously to start on hygiene. On many occasions, Child 2 refused to shower or wash her hair. On 1/31/2025, Child 2 told staff the water hitting her skin made her feel uncomfortable. Record review on 7/8/2025 of Child Abuse Assessment 2025143104 indicated during an interview on 5/25/2025 Child 2 stated the water during a shower felt like sharp nails on her skin. She said she was supposed to be getting occupational therapy to help her manage the stress of showering, but she had not yet received that since being at Children's Square. Record review on 7/8/2025 revealed the facility's policy for Physical Interventions, dated 4/3/2025 stated physical intervention may be used if there was an immediate danger of harm to self or others. In neither of these instances did Child 1 or Child 2 pose a risk of immediate danger of harm to themselves or others requiring physical intervention.	N 132	The Leadership confirmed that the hygiene chart for the youth is kept outside of the EHR and would not be located in the youth's file, however, the physical hygiene reward chart will be kept in the youth's room in a private place. Compliance with the reward chart will be monitored by the YSS staff each morning and documented for the therapist to review with the youth. The Leadership team identified that the documentation of our attempts to secure Occupational therapy for the child was not located in the client electronic record. Documentation of our attempts to secure this service for this child and the results were being stored in a "case file" tab in the EHR that was not accessible to the Reviewer. Leadership acknowledges that this information (emails with Caseworker and notes from MCO meetings) should have been included in the care plan, discharge planning and quarterly reports. This has been communicated to the Treatment Manager and will be reviewed and monitored by the Clinical Director and PMIC Director. Upon review of this incident, the Leadership team in conjunction with the HR manager and the Quality and Special Projects Manager acknowledge that this incident is inappropriate; the youth was not at imminent risk; and there was not proper documentation of the incident. The following steps have been taken to ensure the protection of residents and proper documentation: • Staff were retrained in de-escalation	07/31/2025 07/31/2025 06/18/2025

			techniques on 06/18/2025 during the regularly scheduled Big Team meeting. • A Mandatory Staff Training was held the week of 07/14/2025 to 07/18/2025 which focused again on de-escalation, CPI, and trauma-informed care. • De-escalation training focused on using verbal de-escalation techniques and physical redirection was also a focus of the training delivered. • Staff who were involved in this incident were immediately suspended to protect the children/youth in the program and then subsequently terminated due to not following proper de-escalation, CPI, and trauma-informed procedures. • All new YSS staff have been certified in CPI as of 7/18/2025 and existing YSS staff have been retrained and recertified in CPI. All YSS received an intensive one-day training on the impact of Trauma through our Certified Risking Connections trainer. Upon learning of this incident, the Leadership recognized the need to re-train staff on the procedures to be used to address behavior with children and youth. In addition to the training, Leadership has increased supervision of staff and conducted performance reviews to ensure there is proper documentation of coaching with staff and disciplinary actions if applicable.	07/18/2025 07/18/2025 05/07/2025- 05/26/2025 07/18/2025 08/01/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16L022	A. BUILDING _____ B. WING _____	C 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHILDREN'S SQUARE- FRIENDS AND FOUNDATION - COTT 1	619 CURTIS STREET CO BLUFFS, IA 51502

(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
N 132	Continued From page 5 When interviewed on 7/9/2025 at 12:30 pm, the Senior Director of Residential Services and Interim Chief Executive Officer stated the facility staff involved did not handle the two situations appropriately.	N 132		
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, the facility failed to include all staff involved in the intervention in the child debriefing. This involved 2 of 2 children (Child 1 and Child 2) involved in investigation #129830-C and 129665-C. Finding follows:	N 188	The Leadership team has confirmed that a debriefing occurred on this critical incident but did not have documentation that all of the staff who participated in the debriefing. It was also found that the documentation of the critical incident did not match the video evidence of the event. In addition, there was not a CPI form in the youth's file which is standard procedure. After investigation, it was determined that one of the staff involved completed the report, however, the YSS Residential Supervisor rejected approval of the report due to details not matching the critical incident report. All CPI and critical incident reports are to be completed by the end of shift when the incident occurred, The CPI report will be reviewed and approved by the supervisor or member of the leadership team who was called to debrief the incident. Standard practice is for when the Campus Supervisor or member of the leadership team is on campus to go to where the hold occurred, debrief individually with the staff involved, and debrief with the youth involved. Documentation of this debriefing is documented on the CPI form. If there is any indication that staff may not have followed the procedure, to ensure safety for all residential youth they will be taken out of ratio and suspended until a full review can be done as described below. Since this incident, the critical incident process has been amended to include a review of all critical incidents by the Clinical and Residential Team within 24 hours. Critical incidents where there are noted procedural concerns will be reviewed by video, when the event has occurred	07/31/2025 07/31/2025

			in an area covered by video. If concerns remain, the PMIC Director, Sr. Residential Director or Clinical Director and HR manager will meet with all staff involved to review what has happened and determine if any further HR action to be taken and will be documented in the employee's HR file.	07/31/2025
			For this incident, the staff involved were suspended from being with youth. Upon further investigation, the staff were subsequently terminated.	05/07/2025- 05/26/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16L022	A. BUILDING _____ B. WING _____	C 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHILDREN'S SQUARE- FRIENDS AND FOUNDATION - COTT 1	619 CURTIS STREET CO BLUFFS, IA 51502

(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
N 188	Continued From page 6 1. Record review on 7/8/2025 revealed Child 1's resident debriefing of the physical restraint on 5/4/2025 involved only Staff A. Documentation of why Staff B and Staff C were not part of the resident debriefing following the restraint could not be located. 2. Record review on 7/8/2025 revealed Child 2's resident debriefing of the physical restraint on 5/17/2025 involved only Staff F. Documentation why Staff D and Staff E were not included could not be located. Record review on 7/8/2025 revealed the facility's policy for Physical Interventions stated staff must document in youth's record that both debriefing sessions (one with youth and staff, and one with all staff involved) took place. This documentation was to include names of those present, names of those excused and any changes to treatment plan as a result of the debriefing. When interviewed on 7/9/2025 at 12:30 pm, the Senior Director of Residential Services verified only one staff member participated in the resident debriefing session.	N 188	The findings of all critical incident reviews that present a potential risk to the children/youth will be documented and maintained to be used for quality and compliance monitoring and to determine the need for additional training of staff or revision of processes. The Quality and Special Projects Manager will monitor and track compliance with procedures and documentation and will inform the Leadership team of their findings.	07/31/2025 07/31/2025
N 202	MEDICAL TREATMENT FOR INJURIES CFR(s): 483.372(c) Staff involved in an emergency safety intervention that results in an injury to a resident or staff must meet with supervisory staff and evaluate the circumstances that caused the injury and develop a plan to prevent future injuries. This ELEMENT is not met as evidenced by: Based on record review and interviews, the	N 202	YSS staff will be retrained to appropriately document all injuries to youth or staff. The current CPI form provides a place for YSS staff to document if a youth reports abuse and what injuries occurred. Supportive interventions will be updated. Nursing is able to document if the youth need further evaluation or treatment. The PMIC Director, Supervisor or Sr. Residential Director will review Critical Incident Reports to verify that this information is included in the documentation.	08/13/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16L022	A. BUILDING _____ B. WING _____	C 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHILDREN'S SQUARE- FRIENDS AND FOUNDATION - COTT 1	619 CURTIS STREET CO BLUFFS, IA 51502

(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
N 202	Continued From page 7 facility failed to hold a meeting to evaluate circumstances of Emergency Safety Interventions leading to injury. This involved 2 of 2 incidents involved in investigation #129830-C and 129665-C. Finding follows: Record review on 7/8/2025 revealed during a physical intervention of Child 1 on 5/4/2025, Child 1 sustained injury to her upper arm. During the physical intervention of Child 2 on 5/17/2025, a staff member sustained bruising on the right arm from biting and scratching. Record review on 7/8/2025 revealed the Physical Intervention Procedure reviewed 1/2021, stated staff involved in a physical intervention that resulted in an injury must meet with supervisory staff, evaluate circumstances that caused the injury and develop a plan to prevent future injuries. Documentation related to child injuries and a plan to prevent future injuries could not be located. When interviewed on 7/9/2025 at 12:30 pm, the Interim Chief Executive Officer and Senior Director of Residential Services verified these discussions had not occurred.	N 202	YSS staff will debrief with supervisory staff if a critical incident occurs with injury. YSS staff will document on the Non-Violent Crisis Intervention Plan the debriefing meeting to include who attended what was discussed, if any follow-up care is needed, and whether there are any changes to the youth's treatment plans.	07/31/2025
N 218	EDUCATION AND TRAINING CFR(s): 483.376(b) Certification in the use of cardiopulmonary resuscitation, including periodic recertification, is required. This ELEMENT is not met as evidenced by:	N 218	YSS staff completed CPR training during the week of 07/14/2025-07/18/2025. The HR manager will do a monthly audit of all personnel files to ensure compliance. Upon review, the Leadership team identified that an error did occur where the wrong certificate was saved in the wrong staff file. This was due to 2 staff having the same last name.	07/18/2025 Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16L022	A. BUILDING _____ B. WING _____	C 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHILDREN'S SQUARE- FRIENDS AND FOUNDATION - COTT 1	619 CURTIS STREET CO BLUFFS, IA 51502

(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
N 218	Continued From page 8 Based on record review and interview, the facility failed to assure staff members had the required certification in the use of cardiopulmonary resuscitation (CPR). This involved 2 of 7 staff members involved in investigation #129830-C and 129665-C. Finding follows: 1. Record review on 7/7/2025 revealed on 5/4/2025 Staff G authorized the restraint of Child 1 and on 5/17/2025 Staff G authorized the restraint of Child 2. Record review on 7/8/2025 revealed Staff G's training records indicated her last CPR certification was on 5/3/2023. Staff G's current certification could not be located. 2. Record review on 7/7/2025 revealed on 5/17/2025 Staff E was involved in the restraint of Child 1. Record review on 7/8/2025 revealed Staff E's training records failed to include a CPR certification on file. When interviewed on 7/9/2025 at 12:30 pm, the Chief Human Resource Director verified Staff E did not have a CPR certification on file. The Chief Human Resource Director verified Staff G did not have a current CPR certification and was scheduled for an upcoming training. The Chief Human Resource Director verified it is Children's Square's policy to provide training for all staff responsible for physical interventions of residents to maintain current certification in CPR.	N 218	YSS staff completed CPR training during the week of 07/14/2025-07/18/2025. The HR manager will do a monthly audit of all personnel files to ensure compliance.	07/18/2025 Ongoing
N 222	EDUCATION AND TRAINING CFR(s): 483.376(f)	N 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16L022	A. BUILDING _____ B. WING _____	C 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHILDREN'S SQUARE- FRIENDS AND FOUNDATION - COTT 1	**619 CURTIS STREET CO BLUFFS, IA 51502**

(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
N 222	Continued From page 9 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. This ELEMENT is not met as evidenced by: Based on record review and interview, the facility failed to assure staff members demonstrated competencies on a semiannual basis as required. This involved 1 of 7 staff members involved in investigation #129830-C and 129665-C. Finding follows: Record review on 7/7/2025 revealed Child 1's restraint dated 5/17/2025 documented Staff E was involved in the restraint of Child 1. Staff E's last documented demonstration of competencies of the safe use of restraint was dated 9/5/2024. Staff E's semiannual demonstration could not be located. When interviewed on 7/9/2025 at 12:30 pm, the Chief Human Resource Director verified this lack of information.	N 222	YSS staff completed CPR training during the week of 07/14/2025-07/18/2025. The HR manager will do a monthly audit of all personnel files to ensure compliance.	07/18/2025 Ongoing