Iowa Department of Inspections, Appeals, and Licensing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 57PM34	(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 NORTH OAKS-PMIC	**5400 KIRWOOD BLVD 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
A0000	Initial Comments The following deficiency was cited during the PMIC survey to determine compliance with Chapter 41 PMIC rules. 135H.3 Nature of care. 1. a. A psychiatric medical institution for children shall provide shelter, food, supervision, care, assessment, evaluation, diagnosis, treatment, counseling, rehabilitative services, and related professional-directed services to youth who have a serious emotional disturbance, a substance use disorder, or both, with the intention of reducing or ameliorating the disorder, the symptoms of the disorder, or the effects of the disorder. b. A psychiatric medical institution for children shall utilize a team of professionals to direct an organized program of diagnostic services, psychiatric services, nursing care, and rehabilitative services to meet the needs of residents in accordance with a medical care plan developed for each resident. The membership of the team of professionals may include but is not limited to an advanced registered nurse practitioner or a physician assistant. Social and rehabilitative services shall be provided under the direction of a qualified mental health professional. Based on document review and interview, the facility failed to ensure an individual hired as a Care Manager met the minimum standards of the position. This affected 1 of 1 caseworkers (Staff D) reviewed. Findings include: Record review om 8/13/2026 revealed Staff D's personnel file documented the facility hired Staff D as a Care Manager on 6/25/2026.Staff D's personnel file documented Staff D obtained a Bachelor's Degree in history from Iowa State University in 2004. Staff D's personnel file documented Staff D had no prior experience managing a caseload or developing an	A0000		

Office of Primary Care and Health Systems Management

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

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A0000	Continued from page 1 individual medical care plan for children. Additional record review revealed the facility's Care Manager job description, revised 6/23/23, indicated the Care Manager was responsible for assuring the success of the children in care. The Care Manager analyzed issues, developed and oversaw execution of the client plan. The Care Manager's responsibilities included assessment, independently applied professional judgment to pinpoint goals and reduce impairments. They developed the treatment plan. Additionally, the Care Manager actively participated in discharge planning, partnered with Direct Care Staff to deliver cost-effective skill development, and selected or adjusted necessary care components. They documented progress, shared relevant information with care team members, evaluated staff service delivery against treatment plan goals, and provided feedback to direct adjustments to service plans. The education section included a Master's Degree plus five years of experience. When interviewed on 8/13/2026 at 10:50 a.m. the Human Resources Specialist confirmed Staff D did not possess the required level of education or experience to hold the position of a Care Manager.	A0000		

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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		
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	E0037		

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.

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E0037	Continued from page 1 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 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.	E0037		

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E0037	Continued from page 2 *[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 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.	E0037		

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E0037	Continued from page 3 (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 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:	E0037		

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E0037	Continued from page 4 Based on record review and interviews, the facility failed to train new staff members in the Emergency Preparedness Plan (EPP). This affected 2 of 3 staff members (Staff C and Staff D) 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 4/23/2026.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 6/25/2026.Staff D'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 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 two staff members had not received initial training in EPP.	E0037		
N0207	FACILITY REPORTING CFR(s): 483.374(b) Reporting of serious occurrences. The facility must report each serious occurrence to both the State Medicaid agency and, unless prohibited by State law, the State designated Protection and Advocacy system. Serious occurrences that must be reported include; - a resident's death; - a serious injury to a resident as defined in section §483.352 of this part; and - a resident's suicide attempt. (1) Staff must report any serious occurrence involving a resident to both the State Medicaid agency and the State designated Protection and Advocacy system by no later than close of business the next business day after a serious occurrence. The report must include - the name of the resident involved in the serious occurrence,	N0207		

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N0207	Continued from page 5 - a description of the occurrence and, - the name, street address, and telephone number of the facility. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the facility failed to report serious occurrences to the State Medicaid agency, Iowa Medicaid Enterprise (IME), and the State-designated Protection and Advocacy system, Disability Rights of Iowa (DRI). This affected 2 of 2 children reviewed (Child 1 and Child 2). Findings follow: 1.Record review on 8/12/2026 revealed Child 1's incident report, dated 11/25/2025, indicated Child 1 hit her elbow on the door latch to her bedroom. The facility took Child 1 to the Emergency Room where aa medical professional applied three sutures to close the wound. No documentation could be provided showing IME had been notified. Additional record review revealed the Quality Compliance Manager emailed DRI of the incident on 12/15/2025. 2. Record review on 8/12/2026 revealed Child 2's incident report, dated 1/19/2026, indicated Child 2 superficially cut both her arm and neck. The facility transferred Child 2 to St Luke's Hospital for psychiatric evaluation. No documentation could be provided showing IME had been notified. Additional record review revealed the Quality Compliance Manager emailed DRI of the incident on 1/23/2026. Record review on 8/13/2026 revealed the facility's Incident Reporting and Management policy, revised 4/11/2024, indicated the Quality Specialist would fax/email reports of serious occurrences to the appropriate recipients by the end of the day following the incident. When interviewed on 8/13/2026 at 12:20 p.m., the Quality and Compliance Manager confirmed the notifications were sent late.	N0207		