STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17PM047	A. BUILDING: _____ B. WING _____	12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR OAKS CAMBRIDGE UNIT	80 N, EISENHOWER MASON CITY, IA 50401

(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 During the license review, the following deficiency was cited during the PMIC survey to determine compliance with Chapter 41 PMIC rules.	A 000	See Attached POC 2/27/26	
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 recommend changes to client plans when they eloped. This affected 6 of 9 children reviewed (Child 1, Child 2, Child 3, Child 4, Child 5, and Child 7). Findings follow: Record review conducted between 10/30/2025 and 11/13/2025 documented 81 elopements in September and October 2025. Examples included but were not limited to the following: 1. Child 1's file contained 14 documented incidents of elopement. Child 1's plan of care contained no recommended changes to reduce this behavior. 2. Child 2's file contained 9 documented incidents of elopement. Child 2's plan of care contained no recommended changes to reduce this behavior.	A 215		

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
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A 215	Continued From page 1 3. Child 3's file contained 14 documented incidents of elopement. Child 3's plan of care contained no recommended changes to reduce this behavior. 4. Child 4's file contained 15 documented incidents of elopement. Child 4's plan of care contained no recommended changes to reduce this behavior. 5. Child 5's file contained 6 documented incidents of elopement. Child 5's plan of care contained no recommended changes to reduce this behavior. 6. Child 7's file contained 5 documented incidents of elopement. Child 7's plan of care contained no recommended changes to reduce this behavior. Additional record review revealed the facility's Run Protocol dated 6/1/2025, indicated the youth's potential for runaway would be assessed at admission, during team and progress management meetings and as frequently as every shift, depending on the youth's assessed risk. Runway precautions would be initiated for all youth who were assessed to be high risk for runaway, made a recent attempt to runaway or verbalizing they may runaway. The protocol listed potential precautions including but not limited to the use of increased supervision, increased checks of the youth and various restrictions to peers, personal items and activities. The protocol specified a debriefing would be conducted following the incident, and the caseworker would schedule a strategy meeting within 24 hours to review and adjust the youth's plan of care. When interviewed on 12/16/2025 at 2:45 pm, the Compliance Manager confirmed the plans of care	A 215		

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
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A 215	Continued From page 2 for the 6 children had not been updated.	A 215		

Re: Four Oaks PMIC (Mason City) Audit
Plan of Correction

1/23/2026

Dear Ms.Campbell,

In accordance with your request for our statement of correction of deficiencies found during a recent PMIC (Cambridge) facility audit conducted October 2025-December 2025, outlined below is the plan of correction our agency is taking to mitigate and prevent future deficiencies.

A step-by-step description of the method(s) used to correct the system level problem which caused the deficiences. The plan of correction must provide information which assures the intent of the regulation as evidenced by examples, is corrected.

We recognize that during the audit, we were deficient with six of nine client's Individual Care Plans in which their care plans did not appear to be reviewed or revised based on their indivdual adjustment to the inpatient setting. More specifically, their care plans did not appear to be revised to addressed the specific concerns of the frequent elopements exhibited by these clients. We have worked diligently to correct our systems to ensure this deficiency has been addressed and will not occur going forward.

Individual Care Plan Review and Revision Process Implemented (since aduit) includes:

- **Agency Run Protocol & Run Screener –** Whenever a client goes AWOL from the PMIC facility and proprety, a PMIC care team member will complete the Run Screener with the client upon their return to the facility. An initial resolution to the critical incident will be included on this report. Following the completion of the run screener and initial resolution, this wil then be sent/referred to the interdisciplinary team for review in the weekly clinical consultation (Progress Management) meeting. Additionally, the client's care manager will provide notification to the guardian and other external team members, and will request a client stafffing or MCM, to review the incident and plan of care.

- **Incident/Behavior Management Reports –** These reports document the critical incident that occurred and the debriefing following the incident. When these reports are completed, they are sent/referred to the interdisciplinary team for review in the weekly clinical consultation (Progress Management) meeting. Through this venue,

the team will review the individual care plan and determine chages needed. Those changes will be outlined as an addendum to the initial resolution in the incident/behavior management report.

- **Weekly Clinical Consultation/Progress Management –** The interdisciplinary team meets each week and reviews all clients who are having frequent incidents and/or behavior management concerns. The team reviews the possible antecedents to the incidents, reviews the immediate intervention utilized, and determines what changes are needed to the individal care plan to reduce/prevent future incidents. The changes determined via this discussion will be outlined in the PMIC 30 day Review Report in additional to the Incident/Behavior Management resolution.

- **PMIC 30 Day Review Report** – This report is utilized to guide the clinical consultation discussion, in conjunction with Incident Reports, to review client areas of progress and areas of needs. Following the interdisciplinary team discussion and decision making, any changes that will be implemented to the individual plan of care will be documented in the PMIC 30 day Review. The PMIC 30 day review is updated as frequently as needed, but no less than every 30 days, and any changes to the individual care plan will be outlined and dated accordingly on this document under the "Focus of Treatment team" section.

State the method(s) to be used to maintain and monitor compliance. Indicate the position(s) responsible for the correction to prevent deficiency's reoccurrance. State your anticipated frequency of monitoring.

To maintain quality and ensure we continuously meet the PMIC standard of reviewing Individual Care Plans at regular intervals, and more frequently as needed based on increased incidents;

- The Program Director will ensure that all mileu staff are properly trained in the Agency Run Protocol and Run Screener Procedures.
- The Program Director will ensure that all mileu staff are properly trained on how to effectively complete the documentation for incidents and behavior managements, and ensure referral of incidents are sent to the interdisciplinary team for review.
- The Care Management Director will be responsible for ensuring that Individual Care Plans are reviewed in clinicial consultation following significant incidents.
- The Care Manager will be responsible for ensuring notification to the guardian and external team members and soliciting input for revisions to the Individual Plan of Care.
- The Care Manager and Care Management Director will be responsible for completing the PMIC 30 Day Review and ensuring that changes to the Individual Care Plan are reflected in the 30 day review as well as completing the resolution in the Incident/Behavior Management Report.
- The Program Director will ensure that all mileu staff are provided the updated Individual Plan of Care and/or have necessary information to implement changes to the plan.

A relealistic date of correction by month, date, and year.

Our team has already implemented the the majority of the corrective action steps outlined. We are in the process of re-training and re-teaching staff members of the process and expectations. Our team will have the re-training process completed no later than February 27, 2026. We are confident the deficiencies found will be resolved and future deficiencies can effectively be prevented by following the plan of correction outlined.

Thank you for your ongoing partnership and support in helping our facility to maintain the high qualtiy standards of PMIC. Should you need further information on our plan of correction, please feel free to contact our team directly.

With Regards,

Mary Chval
Compliance Manager
Four Oaks
Cell 319-471-3982
Desk 319-784-2041
mchval@fouroaks.org