IOWA DEPARTMENT OF PUBLIC HEALTH
DIVISION OF BEHAVIORAL HEALTH

90 DAY FOLLOW UP INSPECTION TO DENIAL

PROGRAM:	*OWI Program/Family Counseling and Psychology Center, PC (OWI Program)* 605 N. Main Street Davenport, Iowa 52803
LICENSED SERVICES:	This program provides Adult and Juvenile Levels 1 and 2.1 Substance Use Disorder Treatment Services
DIVISION SURVEYORS:	Lori Hancock-Muck and Amanda McCurley Division of Behavioral Health
INITIAL NOTICE OF DENIAL FROM COMMITTEE:	March 11, 2020
CORRECTIVE ACTION APPROVAL:	April 9, 2020
90 DAY FOLLOW UP INSPECTION:	October 9, 2020

SUMMARY OF FOLLOW UP INSPECTION FINDINGS:
Corrective Action Plan Compliance Summary:

OVERALL COMPLIANCE –

- ***13 of 23 licensure standards are now in compliance.***
- ***5 of 23 licensure standards remain in non-compliance.***
- ***5 of 23 licensure standards are in partial compliance.***

Compliance:

1. ***641-155.17 License Revision***
2. ***641-155.21(5)c Staff Development and Training***
3. ***641-155.21(8)d. Personnel***
4. ***641-155.21(9)d. Child Abuse, Dependent Adult Abuse and Criminal History Background Checks***
5. ***641-155.21(12)a. Treatment Plans***

6. ***641-155.21(14)a. Patient Record Contents***
7. ***641-155.21(14)b. Patient Record Contents***
8. ***641-155.21(17)c. Emergency Services***
9. ***641-155.21(19)d. Management of Care and Discharge Planning***
10. ***641-155.21(20)b. Quality Improvement***
11. ***641-155.21(20)c. Quality Improvement***
12. ***641-155.21(20)d. Quality Improvement***
13. ***641-155.21(20)e. Quality Improvement***

Non-Compliance:

1. ***641-155.21(6) Data Reporting***
2. ***641-155.21(11)c. Assessment and Admission***
3. ***641-155.21(19) Management of Care and Discharge Planning***
4. ***641-155.21(19)b. Management of Care and Discharge Planning***
5. ***641-155.21(20)f. Quality Improvement***

Partial Compliance:

1. ***641-155.21(8)c. Personnel***
2. ***641-155.21(11)d. Assessment and Admission***
3. ***641-155.21(11)e. Assessment and Admission***
4. ***641-155.21(12)c. Treatment Plans***
5. ***641-155.21(21)c. Facility Safety and Cleanliness***

SUMMARY OF DENIAL:

On November 25, 2019, Division surveyors conducted a licensure on-site inspection of OWI Program. As a result, it was determined OWI Program had failed to achieve the minimum licensure weighting report rating (70%) required for a license pursuant to rule 641–155.10(1)(b) and repeated failure to comply with past corrective action plans pursuant to rule 641–155.10(1)(d)(16). Specifically the program received a 56.7% score in Clinical Standards and failed to comply with written corrective action plan issued in 2017. The corrective action plan from 2017 demonstrated repeated failure to comply with the following rules:

- ***641—155.21(11)e. Assessment and Admission***

  Assessment and admission was in non-compliance because the patient record did not contain documentation that the patient had been informed of safety and emergency procedures. *(This was an area of non-compliance during the inspection in 2017).*

- ***641—155.21(12)c. Treatment Plans***

  Treatment plans was in non-compliance because there was no evidence that the patient was provided a copy of the treatment plan. *(This was an area of non-compliance during the inspection in 2017)*

On March 11, 2020, the Substance Abuse/Problem Gambling Program Licensure Committee (Committee) proposed to deny OWI Program's application for a program license due to OWI

Program's failure to achieve the minimum licensure weighting report rating and repeated failure to comply with a past corrective action plan.

In accordance with IAC 641—155.11(2), OWI Program submitted a written corrective action plan addressing the 23 areas of non-compliance. The corrective action was approved by the Department on April 9, 2020. Pursuant to 641 IAC 155.11(2)a., OWI Program had 90 days to show compliance with the plan. In 90 days OWI Program was to demonstrate compliance with the following rules:

- ***641-155.17 License Revision***

License revision was in non-compliance the program did not provide 30 day notice to the division of a program name change. The program communicated the name change to the division at the time of re-application.

- ***641-155.21(5)c. Staff Development and Training***

Staff development and training was in non-compliance because not all personnel records contained evidence that new staff received an orientation on the following: an overview of the program and licensed program services; confidentiality; tuberculosis and blood-borne pathogens, including HIV/AIDS; culturally and environmentally specific information; specific staff responsibilities; and community resources specific to the staff person's responsibilities.

- ***641-155.21(6) Data Reporting***

Data reporting was in non-compliance because no data has been reported to the state since July 25, 2018.

- ***641-155.21(8)c. Personnel***

Personnel was in non-compliance because not all staff had annual performance evaluations.

- ***641-155.21(8)d. Personnel***

Personnel was in non-compliance because not all personnel records contained evidence of completed job performance evaluations, current professional credentials, or documentation of review and agreement to adhere to confidentiality laws and regulations.

- ***641-155.21(9)d. Child Abuse, Dependent Adult Abuse and Criminal History Background Checks***

Child abuse, dependent adult abuse and criminal history background checks was in non-compliance because not all staff had documentation of completing two hours of training on identification and reporting of child abuse and dependent adult abuse within six months of initial employment and two hours of additional training every five years thereafter.

- ***641-155.21(11)c. Assessment and Admission***

Assessment and admission was in non-compliance because there was no evidence that assessments were updated within the period of time specific for each level of care (every 30 days for Level 1 Outpatient).

- ***641-155.21(11)d. Assessment and Admission***

Assessment and admission was in non-compliance because the patient record did not show evidence that the results of the assessment had been explained to the patient and family, if appropriate.

- ***641-155.21(11)e. Assessment and Admission***

Assessment and admission was in non-compliance because the patient record did not contain documentation that the patient had been informed of safety and emergency procedures. *(This was an area of non-compliance during the inspection in 2017).* In addition, the patient record did not contain documentation that the patient had been informed of the nature and goals of the program, the rules governing patient conduct and infractions that can lead to discharge, the cost of service to be borne by the patient, the patient rights and responsibilities, and confidentiality laws, rules, and regulations.

- ***641-155.21(12)a. Treatment Plans***

Treatment plans was in non-compliance because treatment plans were not developed within 30 days of admission.

- ***641-155.21(12)c. Treatment Plans***

Treatment plans was in non-compliance because there was no evidence that the patient was provided a copy of the treatment plan. *(This was an area of non-compliance during the inspection in 2017)*

- ***641-155.21(14)a. Patient Record Contents***

Patient record contents was in non-compliance because patient records did not contain treatment consent forms.

- ***641-155.21(14)b. Patient Record Contents***

Patient record contents was in non-compliance because patient records did not contain management of care reviews (ASAM continued stay and transfer/discharge reviews).

- ***641-155.21(17)c. Emergency Services***

Emergency services was in non-compliance because emergency services information was not posted at the Rock Island office location.

- ***641-155.21(19) Management of Care and Discharge Planning***

Management of care and discharge planning was in non-compliance because the patient record did not demonstrate the proper use of The ASAM Criteria for continued service and discharge decisions.

- ***641-155.21(19)b. Management of Care and Discharge Planning***

Management of care and discharge planning was in non-compliance because the program was not conducting management-of-care activities within the time frames specified for each level of care (every 30 days for Level 1 Outpatient).

- ***641-155.21(19)d. Management of Care and Discharge Planning***

Management of care and discharge planning was in non-compliance because patient records did not contain evidence that discharge planning was initiated at the time of patient admission.

- ***641-155.21(20)b. Quality Improvement***

Quality improvement was in non-compliance because there was no current quality Improvement plan. The quality improvement plan was to be implemented in 2020.

- ***641-155.21(20)c. Quality Improvement***

Quality improvement was in non-compliance because the program did not document whether the quality of patient care and program operations were improved and identified problems are resolved, as there was no current quality improvement plan provided.

- ***641-155.21(20)d. Quality Improvement***

Quality improvement was in non-compliance because the program did not communicate the quality improvement activities and findings to all staff.

- ***641-155.21(20)e. Quality Improvement***

Quality improvement was in non-compliance because the program did not use the quality improvement plan findings to detect trends, patterns of performance, and potential problems that affect patient care and program operations as no current plan was provided.

- ***641-155.21(20)f. Quality Improvement***

Quality improvement was in non-compliance because the program did not evaluate the effectiveness of the quality improvement plan at least annually, as no current plan was provided.

- ***641-155.21(21)c. Facility Safety and Cleanliness***

Facility safety and cleanliness was in non-compliance because there was no evidence for proper handling and storage of biohazardous material at the Rock Island office location, and both locations (Davenport and Rock Island) did not have evidence of prohibition against weapons possession at each location.

RESULTS OF 90 DAY FOLLOW UP INSPECTION:

Due to COVID-19, the Department was unable to conduct a 90 day follow up om-site inspection at OWI Program. As a result the Department decided to conduct a desk audit in lieu of the on-site inspection. On July 6, 2020, Division surveyors contacted OWI Program's Executive Director, Collin Lodico, to request documents to determine compliance with the corrective action plan. The following is a summary of current adherence for each of the 23 licensure standards that were found to be in non-compliance from the November 29, 2019 inspection:

- ***641-155.17 License Revision***

License revision was in non-compliance the program did not provide 30 day notice to the division of a program name change. The program communicated the name change to the division at the time of re-application.

OWI Program's corrective action plan noted the program would provide the Department with 30 day notice for any future revision changes. Over the last 90 days, OWI Program did not have any license revisions required to be reported to the Department. The Department finds the program is in adherence with the corrective action plan.

COMPLIANCE: Compliant

- ***641-155.21(5)c Staff Development and Training***

Staff development and training was in non-compliance because not all personnel records contained evidence that new staff received an orientation on the following: an overview of the program and licensed program services; confidentiality; tuberculosis and blood-borne pathogens, including HIV/AIDS; culturally and environmentally specific information; specific staff responsibilities; and community resources specific to the staff person's responsibilities.

OWI Program's corrective action plan noted a staff orientation would be held at the facility to include an overview of all licensed required elements. Surveyors reviewed four personnel records. Surveyors found evidence in all four personnel records that all staff had received an

orientation addressing all of the required elements. The Department finds the program is in adherence with the corrective action plan.
COMPLIANCE: Compliant

- ***641-155.21(6) Data Reporting***

Data reporting was in non-compliance because no data has been reported to the state since July 25, 2018.
In June 2020, Mr. Lodico contacted the surveyor to notify the department that he was advised not to proceed with the data reporting requirements until he received official permission from the Federal Bureau of Prisons. A few days following the correspondence, Melissa Acevedo, Supervisor with the Federal Bureau of Prisons contacted the surveyor to inquire about the state data reporting requirements. The surveyor provided Ms. Acevedo with supporting documents outlining that Iowa licensed substance use disorder treatment programs are legally required to provide patient information to the Department under the authority outlined in state statue and administrative rule and that there are no provisions in HIPAA or 42 CFR Part 2 which prohibit such reporting. No further communication was received regarding data reporting from Ms. Acevedo or from Mr. Lodico. At the 90 day follow up, surveyors reviewed data integrity reports and determined that OWI Program had not been reporting required data to the state. The Department finds the program has continued to remain in non-compliance with data reporting since July 2018.
COMPLIANCE: Non-Compliant

- ***641-155.21(8)c Personnel***

Personnel was in non-compliance because not all staff had annual performance evaluations.
OWI Program's corrective action plan noted all personnel would receive a performance evaluation within 30 days of the implementation of the corrective action plan. Surveyors reviewed four personnel records. All four records contained evidence of annual performance evaluations, however the evaluations did not include the opportunity for the staff person to comment. Pursuant to 641-155.21(8)c, the evaluation shall include the opportunity for the staff person to comment. The Department finds the program is in partial adherence with the corrective action plan as the performance evaluation does not allow the opportunity for staff comment.
COMPLIANCE: Partial Compliance

- ***641-155.21(8)d Personnel***

Personnel was in non-compliance because not all personnel records contained evidence of completed job performance evaluations, current professional credentials, or documentation of review and agreement to adhere to confidentiality laws and regulations.
OWI Program's corrective action plan noted all personnel records would contain the licensure required elements. Surveyors reviewed four personnel records. All four records contained evidence of job performance evaluations, current professional credentials and documentation

of review and agreement to adhere to confidentiality laws and regulations. The Department finds the program is in adherence with the corrective action plan.
COMPLIANCE: Compliant

- ***641-155.21(9)d. Child Abuse, Dependent Adult Abuse and Criminal History Background Checks***

Child abuse, dependent adult abuse and criminal history background checks was in non-compliance because not all staff had documentation of completing two hours of training on identification and reporting of child abuse and dependent adult abuse within six months of initial employment and two hours of additional training every five years 641-155.21(11)c.
OWI Program's corrective action plan noted personnel records would contain evidence of two hours of training on identification and reporting of child abuse and dependent adult abuse and that any new staff would receive this training within six months of employment. Surveyors reviewed four personnel records and all records contained evidence that staff completed two hours of training on identification and reporting of child abuse and dependent adult abuse. The Department finds the program is in adherence with the corrective action plan.
COMPLIANCE: Compliant

- ***641-155.21(11)c. Assessment and Admission***

Assessment and admission was in non-compliance because there was no evidence that assessments were updated within the period of time specific for each level of care (every 30 days for Level 1 Outpatient).
OWI Program's corrective action plan noted a continuing stay review form will be completed every 30 days and the reviews would update the ASAM criteria. Surveyors reviewed five patient records. Although all records contained evidence that assessments were updated with a documented ASAM review not all records contained a review every 30 days as required for outpatient level of care. The Department finds the program is not in adherence with the corrective action plan.
COMPLIANCE: Non-Compliant

- ***641-155.21(11)d. Assessment and Admission***

Assessment and admission was in non-compliance because the patient record did not show evidence that the results of the assessment had been explained to the patient and family, if appropriate.
OWI Program's corrective action plan indicated a form signed by the patient would show the results of the assessment were explained to the patient. Surveyors reviewed five patient records. Four of the five records had a documented assessment prior to the implementation of the corrective action plan, yet an attestation form was signed by patients several months following the assessment. The form was signed by the patient and attested that the results of the assessment were explained to the patient and the patient was allowed to ask questions about the results. This signed attestation form was found in all but one patient record. The Department finds the program in partial compliance as not every record contained evidence that the result of the assessment had been explained to the patient.

COMPLIANCE: Partial Compliance

- ***641-155.21(11)e. Assessment and Admission***

Assessment and admission was in non-compliance because the patient record did not contain documentation that the patient had been informed of safety and emergency procedures. (This was an area of non-compliance during the inspection in 2017). In addition, the patient record did not contain documentation that the patient had been informed of the nature and goals of the program, the rules governing patient conduct and infractions that can lead to discharge, the cost of service to be borne by the patient, the patient rights and responsibilities, and confidentiality laws, rules, and regulations.

OWI Program's corrective action plan indicated a signed form would be in each patient record acknowledging the patient had been informed of safety and emergency procedures, nature and goals of the program, rules governing patient conduct and infractions that can lead to discharge, patient rights and responsibilities and confidentiality laws, rules, and regulations. The program's corrective action plan indicated there is no cost for services to the patient and the Bureau of Prisons covers costs of treatment services as stipulated in the federal contract. Surveyors reviewed five patient records to find evidence that the patient had been informed of all the elements with the exception of cost of service to be borne by the patient as services are provided at no costs to patients. An attestation form, signed by the patient, was found in four of the five records. The form included all required elements with the exception of safety and emergency procedures. A patient signed "Welcome to Community Treatment Service" form was found in four of the five patient records. This form did include a section on safety and emergency procedures. The Department finds the program to be in partial compliance as one patient record did not include evidence that the patient was informed of safety and emergency procedures and one patient record did not contain evidence that the patient was informed of the nature and goals of the program, the rules governing patient conduct and infractions that can lead to discharge, the patient rights and responsibilities, and confidentiality laws, rules, and regulations.

COMPLIANCE: Partial Compliance

- ***641-155.21(12)a. Treatment Plans***

Treatment plans was in non-compliance because treatment plans were not developed within 30 days of admission.

OWI Program's corrective action plan noted treatment plans would be completed in the time frame afforded by the Bureau of Prisons contract and this generally take "a little longer than 30 days." Surveyors reviewed five patient records. Four records did not include treatment plans developed within 30 days of admission but these patients were admitted prior to the implementation of the corrective action plan. One patient was admitted following implementation of the corrective action plan and the treatment plan was developed within the 30 days of admission. The Department finds the program is in adherence with the corrective action plan.

COMPLIANCE: Compliant

- ***641-155.21(12)c. Treatment Plans***

Treatment plans was in non-compliance because there was no evidence that the patient was provided a copy of the treatment plan. (This was an area of non-compliance during the inspection in 2017)

OWI Program's corrective action plan indicated a signed form would be in each patient record acknowledging the patient was offered a copy of the treatment plan. Surveyors reviewed five patient records. Four of the five records had a form signed by the patient that attested that patient was offered a copy of the treatment plan. This signed attestation form was found in all but one patient record. The Department finds the program is in partial compliance as not all records contained evidence that the patient was provided a copy of the treatment plan.

COMPLIANCE: Partial Compliance

- ***641-155.21(14)a. Patient Record Contents***

Patient record contents was in non-compliance because patient records did not contain treatment consent forms.

OWI Program's corrective action plan indicated all patient records would contain a copy of the treatment consent form that would be signed by the patient. The surveyors reviewed five patient records and all five records contained a signed treatment consent form. The Department finds the program is in adherence with the corrective action plan.

COMPLIANCE: Compliant

- ***641-155.21(14)b. Patient Record Contents***

Patient record contents was in non-compliance because patient records did not contain management of care reviews (ASAM continued stay and transfer/discharge reviews).

OWI Program's corrective action plan indicated a continuing stay review form will be completed every 30 days and these reviews will update the ASAM Criteria. The surveyors reviewed five patient records and although some reviews were not completed in a timely manner, all five records contained ASAM continued stay reviews. The Department finds the program is in adherence with the corrective action plan.

COMPLIANCE: Compliant

- ***641-155.21(17)c. Emergency Services***

Emergency services was in non-compliance because emergency services information was not posted at the Rock Island office location.

OWI Program's corrective action plan indicated no patients are seen at the Rock Island office and emergency posting was not required. Surveyors informed Mr. Lodico that since this was a licensed location, emergency service information was required to be posted at the facility. At the 90 day follow up, surveyors asked Mr. Lodico to send a picture of the emergency services posting at the Rock Island facility. Mr. Lodico was able to send a picture of the emergency after hours posting from that facility. The Department finds the program is in adherence with the corrective action plan.

COMPLIANCE: Compliant

- ***641-155.21(19) Management of Care and Discharge Planning***

Management of care and discharge planning was in non-compliance because the patient record did not demonstrate the proper use of The ASAM Criteria for continued service and discharge decisions.

OWI Program's corrective action plan indicated "continuing stay reviews using ASAM criteria would be completed every 30 days." Surveyors reviewed five patient records. Although ASAM reviews were found to be documented in all five records, most of the documentation was handwritten and illegible making it unclear if the program demonstrated proper use of The ASAM Criteria for continued service and discharge decisions. The Department finds the program is not in adherence with the corrective action plan

COMPLIANCE: Non-Compliant

- ***641-155.21(19)b. Management of Care and Discharge Planning***

Management of care and discharge planning was in non-compliance because the program was not conducting management-of-care activities within the time frames specified for each level of care (every 30 days for Level 1 Outpatient).

OWI Program's corrective action plan indicated continuing stay reviews using ASAM criteria would be completed every 30 days for each patient. The surveyors reviewed five patient records. The surveyor reviewed ASAM continued stay reviews which were documented from the implementation date of the corrective action plan (April 9, 2020). The surveyor found at least one ASAM review for each record was not conducted every 30 days as required for outpatient level of care. The Department finds the program is not in adherence with the corrective action plan

COMPLIANCE: Non-Compliant

- ***641-155.21(19)d. Management of Care and Discharge Planning***

Management of care and discharge planning was in non-compliance because patient records did not contain evidence that discharge planning was initiated at the time of patient admission.

OWI Program's corrective action plan noted "patients are assigned with a start date and end date that cannot be altered…tracking client progress is an ongoing part of discharge planning through monthly progress reports." The surveyors reviewed five patient records. All records contained evidence of discharge planning which was initiated at the time of patient admission. The Department finds the program is in adherence with the corrective action plan.

COMPLIANCE: Compliant

- ***641-155.21(20)b. Quality Improvement***

Quality improvement was in non-compliance because there was no current quality Improvement plan. The quality improvement plan was to be implemented in 2020.

Surveyors requested a quality improvement plan from OWI Program. Mr. Lodico responded to the surveyor that he was not sure what was being requested with an "actual quality improvement plan." The surveyor responded to Mr. Lodico with OWI Program's corrective action plan that addressed quality improvement plan as follows:

- *A Quality Improvement plan and quality improvement procedures will be developed. A Quality improvement meeting will take place quarterly to discuss progress, problems and needed adjustments to the program. This meeting will be documented with each member in attendance signing the documentation. Furthermore, FCPC undergoes audits conducted by the BOP. Part of Quality Improvement will be to respond to these audits and make needed improvements as identified by the BOP. Quality Improvement will also include tracking the number of Behavioral Incident Reports that are filed each quarter and keeping track of the number of relapses each quarter. The goal will be to learn from relapses and Behavioral Incidents Reports and make indicated changes to the program to reduce the number of relapses and Behavioral Incident Reports.*

Mr. Lodico submitted quality improvement activity documents to the surveyors. Surveyors reviewed the quality improvement plan and found the plan to be acceptable. The Department finds the program is in adherence with the corrective action plan.
COMPLIANCE: Compliant

- ***641-155.21(20)c. Quality Improvement***

Quality improvement was in non-compliance because the program did not document whether the quality of patient care and program operations were improved and identified problems are resolved, as there was no current quality improvement plan provided.
Surveyors reviewed OWI Program's quality improvement activities. OWI Program had developed a patient checklist to track and ensure all documentation is completed for each patient. Furthermore, a weekly patient sheet was developed to monitor and ensure that patient services are being completed in a timely manner. OWI Program determined to purchase the "Maintaining Positive Change" booklets from The Change Companies to integrate into the program. Finally, OWI Program noted the plan included tracking behavioral problems within the patient population. It was noted that Behavioral Incident Reports would be sent to the Bureau of Prisons whenever there was a behavioral incident. The incidents would be monitored by the number and type of incident occurring. The Department finds the program is in adherence with the corrective action plan.
COMPLIANCE: Compliant

- ***641-155.21(20)d. Quality Improvement***

Quality improvement was in non-compliance because the program did not communicate the quality improvement activities and findings to all staff.
OWI Program provided surveyors with a quality improvement plan that noted staff would be involved in bimonthly meeting to track the progress and needs of each patient. In addition to these meetings, it was noted ongoing email correspondence and phone calls would be conducted with the counselors at the center. OWI Program's quality improvement plan noted "committed to quality is reflected in our efforts at ongoing communication with the center staff to ensure that each client's needs are tracked, discussed and addressed." Surveyors were provided with examples of quality improvement meeting minutes where this communication

was demonstrated. The Department finds the program is in adherence with the corrective action plan.
COMPLIANCE: Compliant

- ***641-155.21(20)e. Quality Improvement***

Quality improvement was in non-compliance because the program did not use the quality improvement plan findings to detect trends, patterns of performance, and potential problems that affect patient care and program operations as no current plan was provided.
OWI Program reported in their quality improvement plan that the Behavioral Incident Report is monitored and tracked monthly. It was reported through their tracking that there have not been any relapses and behavioral issues that were discussed with the center staff and the Bureau of Prisons. It was further noted that as part of the quality improvement activities, OWI Program maintains communication with the Bureau of Prisons about any of their concerns and is open to their feedback. Examples of the Behavioral Incident Report were provided to surveyors. The Department finds the program is in adherence with the corrective action plan.
COMPLIANCE: Compliant

- ***641-155.21(20)f. Quality Improvement***

Quality improvement was in non-compliance because the program did not evaluate the effectiveness of the quality improvement plan at least annually, as no current plan was provided.
OWI Program noted in their quality improvement plan that "We have not been audited during this trial period, but we will include the last audit that took place. We will continue to look for ways to improve our services as we believe that quality improvement is an ongoing mindset stemming from a desire to serve people in the best way possible." Surveyors were provided with a U.S. Department of Justice Federal Bureau of Prisons audit dated August 15, 2019 along with OWI Program's response to addressing the audit's two findings of non-compliance. Although the submitted document may be considered a quality improvement activity, the surveyors did not find evidence that OWI Program had evaluated the effectiveness of the program's quality improvement plan. Although an external review of the program was conducted, surveyors were unable to find an internal evaluation of the effectiveness of the identified quality improvement plan. The Department finds the program is not in adherence with the corrective action plan
COMPLIANCE: Non-Compliant

- ***641-155.21(21)c. Facility Safety and Cleanliness***

Facility safety and cleanliness was in non-compliance because there was no evidence for proper handling and storage of biohazardous material at the Rock Island office location, and both locations (Davenport and Rock Island) did not have evidence of prohibition against weapons possession at each location.
Surveyors asked Mr. Lodico to send a picture of the biohazard kit and prohibition against weapons signage. Mr. Lodico was able to send a picture of the biohazard kit and the sign prohibiting weapons appropriately displayed at the Rock Island office. Mr. Lodico informed

surveyors that prohibition against weapons possession cannot be posted at the Davenport location due to the facility being a Work Release Center and is a locked facility with armed guards. Mr. Lodico indicated in the corrective action plan that as a result, a petition of waiver would be submitted to have the requirement of prohibition against weapons signage be waived. The Department did not receive a petition of waiver from the program. The Department finds the program is in partial compliance as the program did not have an approved waiver to suspend the requirement of prohibited against weapons possession at the Davenport location.

COMPLIANCE: Partial Compliance

RECOMMENDATIONS:

The Department determined of the 23 areas of noncompliance, the program demonstrated the following compliance:

- ***13 of 23 licensure standards are now in compliance.***
- ***5 of 23 licensure standards remain in non-compliance.***
- ***5 of 23 licensure standards are in partial compliance. (2 of the 5 were noted on the initial denial as failure to comply with a corrective action plan from 2017).***

As the Department finds OWI Program to be in 78% compliance/partial compliance with previously submitted corrective action plans, the Department recommends the Committee issue a two year license with an effective date of November 5, 2019 to November 5, 2021 contingent upon the program's adherence with the following:

- Submission of a corrective action plan addressing all current report findings of non-compliance and partial non-compliance within 30 days of the Committee's approval of the recommendations.
- Following submission, the Department will review the corrective action to determine if the plan is acceptable. Once the plan is approved by the Department, OWI Program will have 60 days to show compliance with the plan. The Department may inspect the licensee, including on-site inspection, to review the implemented corrective measure and report to the Committee.

In the event OWI Program does not agree to the recommendations or violates or fails to comply with the recommendations, the Committee may initiate appropriate action to deny, suspend, or revoke OWI Program's license or to impose other appropriate disciplinary action.

Addendum – November 23, 2020

Following completion of this report, the Department sent Mr. Lodico a copy of the report prior to the December 9, 2020 Committee meeting. Mr. Lodico then provided a written response which is attached to this report. In the part of his response, Mr. Lodico noted he had submitted a waiver petition to the Department on March 23, 2020. The waiver petition was to waive the administrative rule regarding weapons prohibition at the Davenport location. Upon further research, the surveyor was able to find evidence the waiver had been submitted to the Department on March 23, 2020, yet had not been processed. The waiver has since been

approved and as a result, the Department recommends the Committee accept the amended finding below:

- ***641-155.21(21)c. Facility Safety and Cleanliness***

Facility safety and cleanliness was in non-compliance because there was no evidence for proper handling and storage of biohazardous material at the Rock Island office location, and both locations (Davenport and Rock Island) did not have evidence of prohibition against weapons possession at each location.

Surveyors asked Mr. Lodico to send a picture of the biohazard kit and prohibition against weapons signage. Mr. Lodico was able to send a picture of the biohazard kit and the sign prohibiting weapons appropriately displayed at the Rock Island office. Mr. Lodico informed surveyors that prohibition against weapons possession cannot be posted at the Davenport location due to the facility being a Work Release Center and is a locked facility with armed guards. Mr. Lodico indicated in the corrective action plan that as a result, a petition of waiver would be submitted to have the requirement of prohibition against weapons signage be waived. *The Department did not receive a petition of waiver from the program, however, Mr. Lodico has since submitted evidence that the petition of waiver was originally sent to the Department on March 23, 2020. The Department has since reviewed and approved this waiver. The Department finds the program is in adherence with the corrective action plan.*

COMPLIANCE: Compliant

Amended Overall Compliance:

- ***14 of 23 licensure standards are now in compliance.***
- ***5 of 23 licensure standards remain in non-compliance.***
- ***4 of 23 licensure standards are in partial compliance. (2 of the 5 were noted on the initial denial as failure to comply with a corrective action plan from 2017).***

As the amended findings show, OWI Program's score remains unchanged with 78% compliance/partial overall compliance, the Department recommends the Committee approves the recommendations noted from the original findings.