FY 2001 *(continued)*					
FACILITY NAME: Woodward Resource Center					
Date citation issued	**Regulatory agency issuing citation**	**Citation received**	**Circumstances regarding violation**	**Corrective action taken**	**How services were or will be affected due to corrective action**
	DIA	W291 – TIME OUT ROOMS A client may be placed in a room from which egress is prevented only if the following conditions are met: (i)The placement is part of an approved systemic time-out program as required by paragraph (b) of this section. (Thus emergency placement of a client in a time-out room is not allowed) (ii)The client is under the direct constant visual supervision of designated staff. (iii)The door to the room is held shut by staff or by a mechanism requiring constant physical pressure from a a staff member to keep the mechanism engaged.	Complaint	See attached Plan of Correction	An improved communication process was put into place to ensure the public school used techniques consistent with those of the person's program as approved by the guardian.
	DIA	1293—TIME OUT ROOMS Clients placed in time-out rooms must be protecgted from hazardous conditions including but not limited to, presence of sharp corners and objects, uncovered light fixtures, unprotected electrical outlets.	Complaint	See attached Plan of Correction	An improved communication process was put into place to ensure the public school used techniques consistent with those of the person's program as approved by the guardian.
	DIA	W294 – TIME OUT ROOMS A record of time-out activities must be kept.	Complaint	See attached Plan of Correction	An improved communication process was put into place to ensure the public school used techniques consistent with those of the person's program as approved by the guardian.
1-16-01	DIA	W124 – PROTECTION OF CLIENTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.	Complaint	See attached Plan of Correction	Processes were revised to ensure consent as needed
2-21-01	DIA	W186 – DIRECT CARE RESIDENTIAL LIVING UNIT STA.. The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.	Complaint	See attached Plan of Correction	Supervision of the individual consumer was increased
2-28-01	DIA	W111 – CLIENT RECORDS The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights.	Complaint	See attached Plan of Correction	The process for inventory of personal property was improved
4-13-01	DIA	W124 – PROTECTION OF CLIENT RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.	Annual Survey	See attached Plan of Correction	Implementation of the revised consent process continued
	DIA	W137 – PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.	Annual Survey	See attached Plan of Correction	Changes were made in individual cases and staff were retrained

FY 2001					
FACILITY NAME: Woodward Resource Center					
Date citation issued	**Regulatory agency issuing citation**	**Citation received**	**Circumstances regarding violation**	**Corrective action taken**	**How services were or will be affected due to corrective action**
9-25-00	DHS	1—ORGANIZATION OUTCOME-BASED STANDARDS FOR PROVIDERS --The WRC will be required to develop an operational plan and program evaluation system that includes a system for monitoring quality services. --WRC will be required to develop a tracking system to identify training that is provided to HCBS staff specific to the requirements of the HCBS program. --HCBS program requires that a service agreement be developed by WRC for SCL services. This service contract was not found to be present in the SCL service delivery system and a service agreement must be developed. --A system to update current release of information forms must be developed and implemented to assure that all Release of Information (ROI) forms are current.	Waiver -- Full Survey	See attached Plan of Correction	Improved person-centered outcome orientation and documentation in HCBS Waiver program
	DHS	5 – CONSUMERS EXERCISE THEIR RIGHTS AND RESPONSIBILITIES – WRC must develop a training system for staff and consumers to support consumers to exercise their rights and responsibilities.	Waiver -- Full Survey	See attached Plan of Correction	Improved person-centered outcome orientation and documentation in HCBS Waiver program
	DHS	8 - CONSUMERS DECIDE WHICH PERSONAL INFORMATION IS SHARED WITH WHOM --WRC must develop a system that assure that ROI forms are in place to assure that personal information about consumers is released with the appropriate authorization of the consumer or their legal representative.	Waiver -- Full Survey	See attached Plan of Correction	Improved person-centered outcome orientation and documentation in HCBS Waiver program
	DHS	10 – CONSUMERS MAKE INFORMED CHOICES ON HOW THEY SPEND THEIR FREE TIME -- WRC must develop a system to assure that consumers activity needs are being honored and supported by staff.	Waiver -- Full Survey	See attached Plan of Correction	Improved person-centered outcome orientation and documentation in HCBS Waiver program
	DHS	15 – CONSUMERS DEVELOP AN ACCOMPLISH PERSONAL GOALS WRC must develop a training and monitoring system to assure that documentation of progress on goals identifies staff strategies and consumer responses to the strategies.	Waiver -- Full Survey	See attached Plan of Correction	Improved person-centered outcome orientation and documentation in HCBS Waiver program
	DHS	16 – MANAGEMENT OF CONSUMERS MONEY IS ADDRESSED ON AN INDIVIDUAL BASIS WRC must develop a money management system that is individualized to the wants, needs and desires of individual consumers.	Waiver -- Full Survey	See attached Plan of Correction	Improved person-centered outcome orientation and documentation in HCBS Waiver program
10-13-00	DIA	W154 – STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.	Complaint	See attached Plan of Correction	Staff were retrained on proper reporting procedures
12-22-00	DIA	W124 – PROTECTION OF CLIENT RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.	Complaint	See attached Plan of Correction	An improved communication process was put into place to ensure the public school used techniques consistent with those of the person's program as approved by the guardian.

FY 2000 *(continued)*					
FACILITY NAME: Woodward Resource Center					
Date citation issued	**Regulatory agency issuing citation**	**Citation received**	**Circumstances regarding violation**	**Corrective action taken**	**How services were or will be affected due to corrective action**
	DIA	W297 – PHYSICAL RESTRAINTS The facility may employee physical restraint only as a health-related protection prescribed by a physician, but only if absolutely necessary during the conduct of a specific medical or surgical procedure, or only if absolutely necessary for client protection during the time that a medical condition exists.	Complaint	See attached Plan of Correction	Clarified policies requiring consent for use of restraint and definition of "medical restraint"
4-11-00	State Fire Marshal	See attached. Annual inspection citing minor violations of State Fire Marshal regulations	Examples would be of the hundreds of doors in our facility, a few were found that didn't latch properly and swung shut; staff or clients forgetting to keep routes of egress free of obstruction.	Plans of correction were given to have corrections made within 6 months and that was done.	Services were minimally affected
8-9-99	Division of Labor	See attached. Annual inspection citing minor violations of Division of Labor regulations	Examples would be minor adjustments required to steam pressure vessels throughout the campus.	Corrections were all made within 6 months.	Services were not affected; however, if corrections were not made, we would not have been issued a certificate to operate the particular vessel being cited.
12-6-99	Division of Labor	See attached. Annual inspection citing minor violations of Division of Labor regulations	Examples would be minor adjustments required to steam pressure vessels throughout the campus.	Corrections were all made within 6 months.	Services were not affected; however, if corrections were not made, we would not have been issued a certificate to operate the particular vessel being cited.

FY 2000					
FACILITY NAME: Woodward Resource Center					
Date citation issued	**Regulatory agency issuing citation**	**Citation received**	**Circumstances regarding violation**	**Corrective action taken**	**How services were or will be affected due to corrective action**
9-17-99	DIA	W249 –PROGRAM IMPLEMENTATION – As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.	Complaint	See attached Plan of Correction	Improved safety by making changes in staff training and supervision in one case.
11-30-99	DIA	W193 – STAFF TRAINING PROGRAM – Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients.	Complaint	See attached Plan of Correction	Improved safety by making changes in staff training and program for one person
12-3-99	DIA	W189 – STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training the enables the employee to perform his or her duties effectively, efficiently, and competently.	Complaint	See attached Plan of Correction	Purchased software to assist in ensuring staff training as scheduled
3-20-00	DIA	W193 – STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients.	Complaint	See attached Plan of Correction	Improved safety by making changes in one person's program (including 1:1 supervision at all times) and staff training for that one program
4-20-00	DIA	W132 – DRUG USAGE Drugs used for control of inappropriate behavior must be used only as in integral part of the client's individual program plan that is directly specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.	Annual Survey	See attached Plan of Correction	Improved policies and practices for use of psychotropic medications
	DIA	W316—DRUG USAGE Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually.	Annual Survey	See attached Plan of Correction	Improved policies and practices for use of psychotropic medications
	DIA	W363 – DRUG REGIMEN REVIEW A pharmacist with input from interdisciplinary team must review the drug regimen of each client at least quarterly.	Annual Survey	See attached Plan of Correction	Improved policies and practices for use of psychotropic medications
	DIA	W440 –EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel.	Annual Survey	See attached Plan of Correction	Established audit of documentation of fire drills that had been held
	DIA	W445 – EVACUATION DRILLS The facility must actually evacuate clients during at least one drill each year on each shift.	Annual Survey	See attached Plan of Correction	Established audit of documentation of fire drills that had been held
5-16-00	DIA	W124 – PROTECTION OF CLIENT RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.	Complaint	See attached Plan of Correction	Clarified policies requiring consent for use of restraint and definition of "medical restraint"
	DIA	W296 – PHYSICAL RESTRAINTS The facility may employ physical restraint only as an emergency measure, but only if absolutely necessary to protect client or others from injury.	Complaint	See attached Plan of Correction	Clarified policies requiring consent for use of restraint and definition of "medical restraint"

FY 1999 *(continued)*					
FACILITY NAME: Woodward Resource Center					
Date citation issued	**Regulatory agency issuing citation**	**Citation received**	**Circumstances regarding violation**	**Corrective action taken**	**How services were or will be affected due to corrective action**
	DIA	W193 – STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients.		See attached Plan of Correction	Improved safety by making changes in policies, practices, supervision, staff training, and mechanical systems
11-19-98	DIA	W206 – INDIVIDUAL PROGRAM PLAN Each client must have an individual program plan developed by an interdisciplinary team that represents the professions, disciplines or service areas that are relevant to: (i) Identifying the client's needs, as described by the comprehensive functional assessments required in paragraph [c] (3) of this section; and (ii) Designing programs that meet the client's needs.	Complaint	See attached Plan of Correction	This identified an isolated error that was corrected.
4-15-99	DIA	W198 – STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.	Annual	See attached Plan of Correction	Improved safety by making changes in policies, practices, supervision, staff training, and mechanical systems
	DIA	W249 – PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.	Annual	See attached Plan of Correction	Improved safety by making changes in policies, practices, supervision, staff training, and mechanical systems
	DIA	W454 – INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections.	Annual	See attached Plan of Correction	Improved safety by making changes in policies, practices, supervision, staff training, and mechanical systems
6-24-99	DIA	W426 – CLIENT BATHROOMS The facility must in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 100 degrees Fahrenheit.	Revisit	See attached Plan of Correction	Improved safety by making a change in practice
4-6-99	State Fire Marshal	See attached. Annual inspection citing minor violations of State Fire Marshal regulations	Examples would be of the hundreds of doors in our facility, a few were found that didn't latch properly and swung shut; staff or clients forgetting to keep routes of egress free of obstruction.	Plans of correction were given to have corrections made within 6 months and that was done.	Services were minimally affected
6-22-99	Division of Labor	See attached. Annual inspection citing minor violations of Division of Labor regulations	Examples would be minor adjustments required to steam pressure vessels throughout the campus.	Corrections were all made within 6 months.	Services were not affected; however, if corrections were not made, we would not have been issued a certificate to operate the particular vessel being cited.

RFI #459
Section 2.46(2), Code of Iowa
PART ONE: Fill in the following three tables:

FY 1999					
FACILITY NAME: Woodward Resource Center					
Date citation issued	**Regulatory agency issuing citation**	**Citation received**	**Circumstances regarding violation**	**Corrective action taken**	**How services were or will be affected due to corrective action**
9-21-98	DIA	W122 – CLIENT PROTECTIONS	Re-Visit	See attached Plan of Correction	Improved safety by making changes in policies, practices, supervision, and mechanical systems
	DIA	W158 – FACILITY STAFFING	Re-Visit	See attached Plan of Correction	Improved safety by making changes in policies, practices, supervision, and mechanical systems
	DIA	W164 – PROFESSIONAL PROGRAM SERVICES Each client must receive professional program services needed to implement the active treatment program defined by each client's individual program plan.	Re-Visit	See attached Plan of Correction	Improved safety by making changes in policies, practices, supervision, and staff training
	DIA	W189— STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.	Re-Visit	See attached Plan of Correction	Improved safety by making changes in policies, practices, supervision, staff training, and mechanical systems
	DIA	W192 – STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.	Re-Visit	See attached Plan of Correction	Improved safety by making changes in policies, practices, supervision, and staff training
	DIA		Re-Visit	See attached Plan of Correction	Improved safety by making changes in policies, practices, supervision, staff training, and mechanical systems
	DIA	W331 NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.	Re-Visit	See attached Plan of Correction	Improved safety by making changes in policies, practices, and documentation
	DIA	W426—CLIENT BATHROOMS The facility must in areas of the facility where clients who have to been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit.	Re-Visit	See attached Plan of Correction	Improved safety by making changes in policies, practices, supervision, staff training, and mechanical systems
9/30/98	DIA/U Of I Hiygienic Lab	D4034 D4084 D4135 D6054 D8024	Annual laboratory certification survey	See attached Plan of Correction	Most laboratory operations were in process of being discontinued at the time. Urine microscopic examinations are now done by an outside lab.
10-5-98	DIA	W154 – STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.	Complaint	See attached Plan of Correction	Helped ensure safety of persons served
11-17-98	DIA	W164 – PROFESSIONAL PROGRAM SERVICES Each client must receive professional program services needed to implement the active treatment program defined by each client's individual program plan.	Revisit	See attached Plan of Correction	Improved safety by making changes in policies, practices, supervision, staff training, and mechanical systems
	DIA	W189— STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.	Revisit	See attached Plan of Correction	Improved safety by making changes in policies, practices, supervision, staff training, and mechanical systems

FY 2001					
FACILITY NAME: Glenwood Resource Center					
Date citation issued	**Regulatory agency issuing citation**	**Citation received**	**Circumstances regarding violation**	**Corrective action taken**	**How services were or will be affected due to corrective action**
9-21-00	State Fire Marshall	Various Physical Plant deficiencies as detailed on attached report.	A periodic visit by the State Fire Marshall discovered physical plant deficiencies.	A Plan of Corrective action was accepted by State Fire Marshall and deficiencies were corrected.	A safer environment has been provided for people who live and work at the facility.
12-8-00	IOSHA	A broken ladder was not discarded, access to a fire extinguisher was blocked and a motor was not properly guarded as detailed on report sent 7-6-01	A general site inspection by IOSHA discovered physical plant deficiencies	All deficiencies were corrected as agreed to with IOSHA hearing officer/	A safer environment has been provided for people who live and work at the facility.

FY 2000					
FACILITY NAME: Glenwood Resource Center					
Date citation issued	**Regulatory agency issuing citation**	**Citation received**	**Circumstances regarding violation**	**Corrective action taken**	**How services were or will be affected due to corrective action**
9-29-99	State Fire Marshall	Various Physical Plant deficiencies as detailed on attached report.	A periodic visit by the State Fire Marshall discovered physical plant deficiencies.	A Plan of Corrective action was accepted by State Fire Marshall and deficiencies were corrected.	A safer environment has been provided for people who live and work at the facility.

RFI #459
Section 2.46(2), Code of Iowa
PART ONE: Fill in the following three tables:

FY 1999					
FACILITY NAME: Glenwood Resource Center					
Date citation issued	**Regulatory agency issuing citation**	**Citation received**	**Circumstances regarding violation**	**Corrective action taken**	**How services were or will be affected due to corrective action**
12-9-98	State Fire Marshall	Various physical plant deficiencies as detailed on report sent via LOCAL mail on 7-6-01	A periodic visit by State Fire Marshall discovered physical plant deficiencies.	A Plan of Correction was accepted by State Fire Marshall and deficiencies were corrected.	A safer environment has been provided for people who li ve and work at the facility.

FY 2001					
FACILITY NAME: **Glenwood Resource Center**					
Date citation issued	**Regulatory agency issuing citation**	**Citation received**	**Circumstances regarding violation**	**Corrective action taken**	**How services were or will be affected due to corrective action**
9-28-00	DIA	Various Title XIX Certification survey deficiencies as noted on report sent 7-6-01	Periodic survey	Plan of Correction submitted and corrections made	Services to the people we serve were enhanced by training and monitoring.
1-11-01	DIA	Various Title XIX Certification survey deficiencies as noted on report sent 7-6-01	Periodic survey	Plan of Correction submitted and corrections made	Services to the people we serve were enhanced by training and monitoring.

FY 2000					
FACILITY NAME: Glenwood Resource Center					
Date citation issued	**Regulatory agency issuing citation**	**Citation received**	**Circumstances regarding violation**	**Corrective action taken**	**How services were or will be affected due to corrective action**
10-7-99	DIA	Various Title XIX Certification survey deficiencies as noted on report sent 7-6-01	Periodic survey	Plan of Correction submitted and corrections made	Services to the people we serve were enhanced by training and monitoring.

RFI #459
Section 2.46(2), Code of Iowa
PART ONE: Fill in the following three tables:

FY 1999					
FACILITY NAME: Glenwood Resource Center					
Date citation issued	**Regulatory agency issuing citation**	**Citation received**	**Circumstances regarding violation**	**Corrective action taken**	**How services were or will be affected due to corrective action**
8-21-98	Department of Inspections and Appeals (DIA)	Various Title XIX Certification survey deficiencies as noted on report sent 7-6-01	Periodic survey	Plan of Correction submitted and corrections made	Services to the people we serve were enhanced by training and monitoring.
12-17-98	DIA	Various Title XIX Certification survey deficiencies as noted on report sent 7-6-01	Periodic survey	Plan of Correction submitted and corrections made	Services to the people we serve were enhanced by training and monitoring.

FY 2001					
FACILITY NAME: Mental Health Institute – Mt. Pleasant					
Date citation issued	**Regulatory agency issuing citation**	**Citation received**	**Circumstances regarding violation**	**Corrective action taken**	**How services were or will be affected due to corrective action**
7/19/00	DIA/HCFA	Non-Compliance with Medicare certification	Cleanliness of food service areas; pest control issues	Daily inspections of all food areas; closely monitor/work with pest control.	Improved cleanliness throughout the institution.
9/01/00	DIA/HCFA	Non-Compliance with Medicare certification	Use of seclusion and/or restraints and when physician must see the patient; need policy stating requirement to contact HCFA when a death occurs; no updated governing body by-laws; some issues missing in medical staff by-laws; physician on-site coverage; physician not in on budget planning process; no physician performance evaluations; medical staff credentials not documented; several dietary policies and procedures not in written form; nutrition screening missing in some records; verification of current dietary director license; verification of dietary worker s' training; sanitizing issues in dietary; ensure electrical appliances brought in by patients are inspected for safety prior to their use.	Policies/procedures were updated; Governing Body by-laws were revised; Quality Assurance procedures updated; Medical Staff by-laws were updated; performance appraisals implemented for physicians; credentials documented; dietary procedures, policies and record keeping updated; dietary director current license is posted in office; nutrition screening procedures were streamlined; dietary worker training planned and implemented on monthly basis; dietary sanitation procedures were improved; on-going systematic inspection of all electrical equipment is conducted and appliances tagged.	Improved, documented services to patients; improved sanitation practices.

FY 2000					
FACILITY NAME: Mental Health Institute – Mt. Pleasant					
Date citation issued	**Regulatory agency issuing citation**	**Citation received**	**Circumstances regarding violation**	**Corrective action taken**	**How services were or will be affected due to corrective action**
5/19/00	State Fire Marshal	Notice to make corrections	Add fire extinguishers; unblock door; put up some signs; add breaker box; replace exit sign bulbs; repair leaking shower; replace missing smoke detector..	All items taken care of.	Improved safety throughout buildings.

FY 2001					
FACILITY NAME:					
Date decertified or threat of de-certification issued	**Regulatory agency issuing de-certification**	**Circumstances regarding de-certification or threat of de-certification**	**Corrective action taken**	**How de-certification will affect services**	**How services were or will be affected due to corrective action**
Not applicable. No citations in this category.					

FY 2000					
FACILITY NAME: Independence Mental Health					
Date decertified or threat of de-certification issued	**Regulatory agency issuing de-certification**	**Circumstances regarding de-certification or threat of de-certification**	**Corrective action taken**	**How de-certification will affect services**	**How services were or will be affected due to corrective action**
Not applicable. No citations in this category.					

PART TWO: **Fill in the following three tables:**

FY 1999					
FACILITY NAME: Independence Mental Health					
Date decertified or threat of de-certification issued	**Regulatory agency issuing de-certification**	**Circumstances regarding de-certification or threat of de-certification**	**Corrective action taken**	**How de-certification will affect services**	**How services were or will be affected due to corrective action**
Not applicable. No citations in this category.					

FY 2001					
FACILITY NAME: Independence Mental Health Institute					
Date citation issued	**Regulatory agency issuing citation**	**Citation received**	**Circumstances regarding violation**	**Corrective action taken**	**How services were or will be affected due to corrective action**
05/24/01	State Fire Marshal	Reynolds buildings – keep laundry close at all time	Annual visit by State Fire Marshal.	Post keep door closed sign on doors	Minimized the effects of smoke and heat in the unlikelihood of a fire
05/24/01	State Fire Marshal	Remove and discontinue storing waste material in corridors.	Annual visit by State Fire Marshal.	Have had Four Oaks remove and they discontinued storing waste materials (waste baskets) in corridors	Avenue to exit not impede in case of need to evacuated
05/24/01	State Fire Marshal	Infirmary Building - North and south stairways must be at least 36" in clear width	Annual visit by State Fire Marshal.	Materials purchased to replace existing stairways with stairways that are 44" in width. Construction drawing have been developed by Shive-Hattery and are being review and approved by the State Fire Marshal Office. Work by Institute staff will begin in FY02.	Wider exit in cases of emergency evacuation like fires.
05/24/01	State Fire Marshal	Infirmary Building - Opening in north stairway enclosure on third floor must be sealed	Annual visit by State Fire Marshal.	Openings are being sealed with fire rate caulk.	Minimized the effects of smoke and heat in the unlikelihood of a fire
05/24/01	State Fire Marshal	Infirmary Building - Remove furnishing and stored material in north stairway	Annual visit by State Fire Marshal.	Material and furnishing moved	Avenue to exit not impede in case of need to evacuated
08/21/00	Department of Inspections and Appeals	A patient alleged complaint against two other patients. During its investigation, the Institute did not interview one patient against whom complaint was made as this patient was being observed continuously by staff at the time of the alleged complaint. Please see attached report for details.	Review by DIA following a mandatory report.	Institute staff were reminded of the hospital policy that when a patient complains about being abused by other patient/s, all alleged patient perpetrators should be interviewed during the course of a complaint investigation. Please see attached report for details.	All alleged patient perpetrators will be interviewed in the future.
06/28/01	Department of Inspections and Appeals	The facility failed to provide adequate supervision on the playground to prevent inappropriate sexual activity between two patients. The Institute did not conduct a thorough investigation into this incident. Please see attached report for details.	Review by DIA following a mandatory report.	The policy for supervision of patients on this unit was revised to more explicitly require staff to visualize all patients during the activities. At the time of making the mandatory report, staff will check with DIA regarding continuing the Institute's own investigation. Please see attached report for details.	Staff responsibility for supervision of patients was clearly assigned.
07/12/00	Iowa Department of Education	IMHI needs to assign surrogate parents to students who do not have parents.	Review by Department of Education.	Procedure was developed to assign surrogate parents to students who need them.	Surrogate parents will be appointed when needed.
07/12/00	Iowa Department of Education	IMHI needs to develop interim IEPs for eligible students who do not have current IEPs when they enter IMHI.	Review by Department of Education.	Procedure was developed to develop an interim or new IEP for eligible students.	An interim or new IEP will be developed.
07/12/00	Iowa Department of Education	IMHI needs to include transition in the notice of IEP meetings for students for which transition is being discussed.	Review by Department of Education.	A procedure was developed to provide notice to parents about IEP meetings where transition would be a topic.	Parents will be notified regarding meeting to discuss transition planning.
07/12/00	Iowa Department of Education	IMHI needs to include statements of transition service needs in the IEPs of students who will turn 14 before their next annual review.	Review by Department of Education.	A procedure was developed for transition services for students ages 13 and up.	Transition planning will occur as required.
07/12/00	Iowa Department of Education	IMHI needs to include statements of needed transition services in the IEPs of students who will turn 16 before their next annual review.	Review by Department of Education.	A procedure was developed for transition services for students who will turn 16 before their next annual review.	Transition planning will occur as required.

FY 2000

FACILITY NAME: Independence Mental Health Institute

Date citation issued	Regulatory agency issuing citation	Citation received	Circumstances regarding violation	Corrective action taken	How services were or will be affected due to corrective action
06/12/00	State Fire Marshal	Reynolds Building – doors to hazardous areas on Ward G such as doors to the laundry room, linen storage, janitors closet and other areas must be equipped with door closers.	Annual visit by State Fire Marshal.	Door closer installed, completed July 20th, 2000	Minimized the effects of smoke and/or heat in the unlikelihood of a fire
06/12/00	State Fire Marshal	Reynolds Building - Repair door to laundry chute in north stairway so close completely and latch.	Annual visit by State Fire Marshal.	Door closer installed, completed July 19, 2000.	Minimized the effects of smoke and/or heat in the unlikelihood of a fire.
06/12/00	State Fire Marshal	Reynolds Building – fire extinguishers uniform located	Annual visit by State Fire Marshal.	Mental Health Institute is evaluating the location and type of extinguishers.	Convince and familiarity of. extinguishers.
06/12/00	State Fire Marshal	Reynolds Building – Repair door west stairway across from Business Office	Annual visit by State Fire Marshal.	Repairs completed July 18, 2000	Minimized the effects of smoke and/or heat in the unlikelihood of a fire.
06/12/00	State Fire Marshal	Witte Building - Replace doors to dayrooms that lead to Ward T and S corridors	Annual visit by State Fire Marshal.	Ward S is being remodeled and doors are being replaced. When Ward S is completed patients form Ward T will be moved to Ward S and remodeling of Ward T will begin. Ward S door frames have been installed and doors ready to install.	Minimized the effects of smoke and heat in the unlikelihood of a fire
06/12/00	State Fire Marshal	Witte Building – fire extinguishers uniform located	Annual visit by State Fire Marshal.	Mental Health Institute is evaluating the location and type of extinguishers	Convince and familiarity of extinguishers
06/12/00	State Fire Marshal	Witte Building – repair doors to laundry chute in Creative Arts and Ward T to close and latch	Annual visit by State Fire Marshal.	Repairs completed July 17, 2000	Minimized the effects of smoke and heat in the unlikelihood of a fire
06/12/00	State Fire Marshal	Witte Building – remove exit sign between library and Ward 22 dayroom	Annual visit by State Fire Marshal.	Remove sign July 17, 2000	Enhance flow of patient and staff during evacuations.
06/12/00	State Fire Marshal	Infirmary Building - North and south stairways must be at least 36" in clear width	Annual visit by State Fire Marshal.	Materials purchased to replace existing stairways with stairways that are 44" in width. Construction drawing have been developed by Shive-Hattery and are being review by the State Fire Marshal Office.	Wider exit in cases of emergency evacuation like fires.
06/12/00	State Fire Marshal	Infirmary Building - Repair door on west stairway so they close and latch	Annual visit by State Fire Marshal.	Door repaired, completed July 17, 2000	Minimized the effects of smoke and heat in the unlikelihood of a fire
06/12/00	State Fire Marshal	Infirmary Building - Furnishing and material in north corridor, third floor	Annual visit by State Fire Marshal.	Removed furnishing and materials	Avenue to exit not impede in case of need to evacuate.
06/12/00	State Fire Marshal	Voc Rehab Building – basement door must close and latch completely	Annual visit by State Fire Marshal.	Repair completed July 14, 2000	Minimized the effects of smoke and heat in the unlikelihood of a fire
06/12/00	State Fire Marshal	Reynolds Building – discontinue renting storage spaces in patient occupied building	Annual visit by State Fire Marshal.	Contacted renter and had them remove their item from the space	Reduces the risk of fire.

RFI #459
Section 2.46(2), Code of Iowa
PART ONE: Fill in the following three tables:

FY 1999					
FACILITY NAME: Independence MHI					
Date citation issued	**Regulatory agency issuing citation**	**Citation received**	**Circumstances regarding violation**	**Corrective action taken**	**How services were or will be affected due to corrective action**
05/10/99	State Fire Marshal	Reynolds Building – doors to hazardous areas on Ward G such as doors to the laundry room, linen storage, janitors closet and other areas must be equipped with door closers.	Annual visit by State Fire Marshal.	Door closer installed	Minimized the effects of smoke and/or heat in the unlikelihood of a fire.
05/10/99	State Fire Marshal	Reynolds Building – provide door closer to the payroll office door	Annual visit by State Fire Marshal.	Door closer installed	Minimized the effects of smoke and/or heat in the unlikelihood of a fire.
05/10/99	State Fire Marshal	Reynolds Building - Repair door to laundry chute in north stairway so close completely and latch.	Annual visit by State Fire Marshal.	Repair completed	Minimized the effects of smoke and/or heat in the unlikelihood of a fire.
05/10/99	State Fire Marshal	Infirmary Building - North and south stairways must be at least 36" in clear width	Annual visit by State Fire Marshal.	Materials purchased to replace existing stairways with stairways that are 44" in width.	Wider exit in cases of emergency evacuation like fires.
05/10/99	State Fire Marshal	Infirmary Building – Repair door between this building and Witte Building on first floor so doors will close completely and latch	Annual visit by State Fire Marshal.	Repair completed	Minimized the effects of smoke and/or heat in the unlikelihood of a fire
05/10/99	State Fire Marshal	Witte Building - Replace doors to dayrooms that lead to Ward T and S corridors	Annual visit by State Fire Marshal.	Ward S is being remodeled and doors are being replaced. When Ward S is completed patients form Ward T will be moved to Ward S and remodeling of Ward T will begin.	Minimized the effects of smoke and heat in the unlikelihood of a fire
05/10/99	State Fire Marshal	Witte Building – Repair doors B16, A15, A17, A20, & A22 on Ward 22 so door close completely and latch	Annual visit by State Fire Marshal.	Repair completed	Minimized the effects of smoke and/or heat in the unlikelihood of a fire.
05/10/99	State Fire Marshal	Steward Hall - Install 1¾" solid wood core door with closer for laundry area	Annual visit by State Fire Marshal.	Door installed	Minimized the effects of smoke and/or heat in the unlikelihood of a fire
05/10/99	State Fire Marshal	Warehouse & Voc Reb building	Annual visit by State Fire Marshal.	Doors kept closed and not wedged open	Minimized the effects of smoke and/or heat in the unlikelihood of a fire
03/10/99	Department of Inspections and Appeals	A Nursing station door was left open. A patient walked into the Nursing station. When he would not leave, a staff member physically removed him from the Nursing station. Please see attached report for details.	Review by DIA following a mandatory report.	Inservice training was provided to Nursing staff emphasizing that physical interaction should be used only after non-physical interactions have proven to be insufficient to insure the safety of everyone involved. Please see attached report for details.	Institute staff reminded to follow hospital policy.
12/22/98	Joint Commision on Accreditation of Healthcare Organizations	The Laboratory's supervisor did not have a documented competency assessment.	Regular biennial survey of the Institute's Medical Laboratory.	The Institute adopted a policy whereby competency of the supervisor will be evaluated by the assistant supervisor and by the Medical Director of the Laboratory.	Competency assessment of the laboratory supervisor will be documented.

FY 2001					
FACILITY NAME: Clarinda Mental Health Institute					
Date citation issued	**Regulatory agency issuing citation**	**Citation received**	**Circumstances regarding violation**	**Corrective action taken**	**How services were or will be affected due to corrective action**
June 11	DIA-OBRA	June 28	Tag F 278=483.20 (g) Resident Assessment	Each Clinical Team member will complete sections of the MDS prior to scheduled team meetings.	Provide accurate and up-to-date material being present in the medical record in a timely manner.
June 11	DIA-OBRA	June 28	Tag F 322=483.25 (g)(2) Quality of Care.	Policy and procedure for individual tube feeding is being revised to include specific procedures for checking the individual tube placement of Nasogastric tubes and Gastrostomy Tubes.	This should ensure appropriate treatment and prevention of aspiration pneumonia, diarrhea, vomiting, dehydration, etc.
March 28	WESTERN IOWA REGIONAL INSPECTIONS	MARCH 28	#23 Plumbing-Water-Sewer No air gap on Ice Machine Drain Line.	Air gap fixed.	Sanitation requirement.
March 28	WESTERN IOWA REGIONAL INSPECITONS	March 28	#29 Facility/ Equipment Requirements Light shield missing in Dishwashing area.	Light shield replaced.	Ensure safety in area.

FY 2000 *(continued)*					
FACILITY NAME: Clarinda Mental Health Institute					
Date citation issued	**Regulatory agency issuing citation**	**Citation received**	**Circumstances regarding violation**	**Corrective action taken**	**How services were or will be affected due to corrective action**
January 6	DIA	February 10	Tag A 185 482.28 (a) Organization.	Annual training of Dietary Department has been developed and implemented with monthly training sessions.	Ensure adequate and timely training for dietary staff.
January 6	DIA	February 10	Tag A 240 482.41 Facilities.	A service contract has been implemented to ensure proper function and calibration on all biomedical machines.	Ensure accurate and timely monitoring of equipment.
January 6	DIA	February 10	Tag A 245 482.42 (a) Organization and Policies.	Policies and Procedures are being updated to include responsibilities of the Infection Control Nurse.	Establishes line of authority for compiling and reporting infections facility wide.
January 6	DIA	February 10	Tag A 306 482.56 (a) Organization and Staffing.	Medical Staff will review qualifications for Physical Therapist, restorative nursing, occupational therapist and activity staff.	To ensure proper review of all staff.
January 6	Fire Marshall	February 10	Tag K 029 NFPA 101 Life Safety Code.	Hazardous areas must be enclosed with one rated construction doors. Staff notified to not use wedges to prop doors. Doors adjusted to close and latch properly.	Ensure safety for all staff and patients.
January 6	Fire Marshall	February 10	Tag K 076 NFPA 101 Life Safety Code	All oxygen bottles will store in secured manner. Portable oxygen bottle rack has been purchased.	Ensure proper safety for all staff and patients.

FY 2000					
FACILITY NAME: Clarinda Mental Health Institute					
Date citation issued	**Regulatory agency issuing citation**	**Citation received**	**Circumstances regarding violation**	**Corrective action taken**	**How services were or will be affected due to corrective action**
April 10	DIA-OBRA	May 17	Tag F 225=483.13 ©(1)(ii) Staff treatment of residents.	DIA inspection results will be done within 5 working days after receiving knowledge of alleged violation involving mistreatment, neglect or abuse.	Assure timely reporting of all investigations.
April 10	DIA-OBRA	May 17	Tag 332=483.25 (m)(1) Quality of Care.	Inservice education regarding medication administration, especially pertaining to proper time of administration.	Ensure safety to patients in the delivery of medication.
January 6	DIA	February 10	Tag A 000 482.13 (e)(f) Restraint for acute medical and surgical care. Restraint and Seclusion for Behavior management.	Restraint and Seclusion Policy rewritten to identify medication to control behavior that is not standard treatment for the patients medical condition.	
January 6	DIA	February 10	Tag A 000 482.45 (a)(1) Organ procurement responsibilities.	Organ procurement policy and agreement formally set up with the State Organ Procurement Agency.	Define the responsibilities of organ procurement and agency of contact.
January 6	DIA	February 10	Tag A 039 482.12 (d) Institutional Plan and Budget.	Institution will work directly with Central Office of DHS to submit budget plan to the State Health Planning Agency annually.	
January 6	DIA	February 10	Tag A 053 482.21 (a) Clinical Plan.	The infection control nurse will separate statistics of nosocomial infections as to acute hospital or Geropsychiatric programs.	Timely reporting of all infections to the appropriate people.
January 6	DIA	February 10	Tag A 097 482.24 (b) Form and retention of record.	The Medical Records Department will maintain a log containing a list of authenticated signatures.	Help maintaining a list of staff signatures in one location.
January 6	DIA	February 10	Tag A 126 482.25 (b) Delivery of Services	The Pharmacy Section has been updated to show that the physician will notified immediately of any medication error.	Timely notification to physician of medication errors.
January 6	DIA	February 10	Tag A 129 482.25 (b) Delivery of Services.	Formulary updated and pharmacy committee meeting every other month.	Accurate reflection of current medications being used. Consistent meeting dates for the P&T committee.
January 6	DIA	February 10	Tag A 183 482.28 (a) Organization.	Dietary section of operational manual updated to reflect current organization of the department.	Accurate listing of current staff.

RFI #459
Section 2.46(2), Code of Iowa
PART ONE: Fill in the following three tables:

FY 1999					
FACILITY NAME: Cherokee Mental Health Institute					
Date citation issued	Regulatory agency issuing citation	Citation received	Circumstances regarding violation	Corrective action taken	How services were or will be affected due to corrective action
5/11/99	Iowa Dept. of Education	(Legal Reference Citation) 300.347(a)(7)(ii)There is no periodic reporting to parents of student progress on Individual Education Plan (IEP) goals. 300.121 Limited time and personnel compromise the ability to fully implement student IEP's thereby limiting the availability of Free Appropriate Public Education (FAPE). 300.180-181 Cherokee MHI does not have policy and procedures in alignment with IDEA '97. 300.347(a)(1)(i) Cherokee MHI has not defined the general education curriculum. 300.346 Cherokee MHI has no procedures for reviewing and revising IEP's, especially for longer term students. 300.347 Cherokee MHI is not monitoring student's progress toward IEP goals. 300.572 Cherokee MHI does not have procedures for the training of staff on confidentiality of records.	Referred to the education program for children and adolescents.	A written corrective action plan was submitted to the Department of Education on 8/30/99. The Department of Education notified Cherokee MHI on 9/23/99 of compliance with special education regulations and removal of the citation.	Changes were implemented so that program was in compliance.

Legislative Fiscal Committee
Section 2.46, Code of Iowa, Citations/Decertification
July 24, 2001

Agency	Department Head	Liaison	Section 2.46 Facility Violations	Section 2.46 Decertification Notices	Comments
Department of Public Heath	Stephen Gleason, Director	David Fries	None	None	DPH does have regulatory authority to conduct inspections of state facilities and may issue citations for violations. Also, investigates complaints against health professionals, private and public contract agencies and other licensed programs within DPH.
Department of Public Safety	Penny Westfall, Commissioner	Robert Heinsen	None	None	
Department of Revenue & Finance	Gerald Bair, Director	Richard Jacobs	None	None	
Secretary of State	Honorable Chet Culver	Donn Stanley		None	
Department of Transportation	Mark Wandro, Director	Ron Juelfs			
Treasurer's Office	Honorable Michael Fitzgerald	Bret Mills	None	None	
Veterans Affairs	Jon Schneider, Director				
Department of Workforce Development	Richard Running, Director	Jane Barto	None	None	

Legislative Fiscal Committee
Section 2.46, Code of Iowa, Citations/Decertification
July 24, 2001

Agency	Department Head	Liaison	Section 2.46 Facility Violations	Section 2.46 Decertification Notices	Comments
Information Technology Services (cont)					January 13, 2000 - State Fire Marshal inspection found 4 deficiencies: remove extension cord from coffee pot, install more outlets in Education Lab 1 & 2, post exit signs in the server farm room, and permanently mount fire extinguisher on the floor of the computer room. Corrective action was taken.
Department of Inspections & Appeals	Kevin Techau, Director	David Werning	None	None	
Iowa Finance Authority	Michael Tramontina, Director				
Iowa Law Enforcement Academy	Gene Shepard, Director	Roger Sitterly	None	None	
Iowa Public Television	David Bolender, Director			None	
Iowa Telecommunications & Technology Comm.	Tommy Thompson, Chief Oper. Officer	Tami Fujinaka	None	None	
Iowa Veterans Home	Jack Dack, Commandant	Rich Riesberg			See Attachment 3
Judicial Department	Honorable Louis Lavorato	Rebecca Colton			
Department of Justice	Honorable Tom Miller	Eric Tabor	None	None	
Department of Management	Cynthia Eisenhauer, Director	Dave Fardal	None	None	
Department of Natural Resources	Jeffrey Vonk, Director	Kathleen Moench	None	None	The Environmental Protection Division has regulatory authority for certain programs and has issued citations to the following areas: Drinking Water - 10 DNR Parks during FY 2000; Drinking Water - 3 Universities during FY 2000; Waste Water Treatment; Underground Storage Tanks; Air Emissions – 2 Universities, Asbestos – G.S. has received 2 to 3 over last 3 years; Road Projects; Storm Water; More information is available upon request.
Parole Board	Clarence Key, Director		None	None	
PERB	Dick Moore, Chair				
Department of Personnel	Mollie Anderson, Director	Mary Ann Hills			
Department of Public Defense - Military Division	Major General Ron Dardis	Duane Jamison	None	None	
Department of Public Defense - Emerg. Mgmt.	Ellen Gordon, Director	David Meyers	None	None	

Legislative Fiscal Committee
Section 2.46, Code of Iowa, Citations/Decertification
July 24, 2001

Agency	Department Head	Liaison	Section 2.46 Facility Violations	Section 2.46 Decertification Notices	Comments
Department of Ag & Land Stewardship	Honorable Patty Judge	Mary Jane Olney	None	None	
Auditor's Office	Honorable Richard Johnson	Warren Jenkins			
Department for the Blind	R. Creig Slayton, Director	Bruce Snethen	None	None	
Board of Regents	Dr. Robert Barak, Director	Pam Elliott			See Attachment 4
Civil Rights Commission	Corlis Moody	Ron Pothast	None	None	
College Student Aid Commission	Gary Nichols, Director	Keith Greiner	None	None	
Department of Commerce	Holmes Foster	Shari Fett	None	None	
Division of Banking	Holmes Foster	Shari Fett	None	None	
Alcoholic Bev. Division	Lynn Walding	Shari Fett	None	None	
Credit Union Division	James Forney	Shari Fett	None	None	
Iowa Utilities Board	Alan Thoms	Shari Fett	None	None	
Department of Corrections	Walter Kautzky, Director	John Baldwin			See Attachment 2
Department of Cultural Affairs	Anita Walker, Director	Mark Peltzman	None	None	
Department of Economic Development	C.J. Niles, Director	Kim Statler	None	None	
Department of Education	Ted Stilwill, Director	Ann McCarthy			
Department of Elder Affairs	Judith Conlin, Director	Stephanie Laudner	None	None	Issues citations to other entities.
Ethics & Campaign Disc. Board	William Smithson, Director		None	None	
Department of General Services	Richard Haines, Director	Jerry Gamble			
Governor's Office	Honorable Tom Vilsack	John Norris	None	None	
GASA	Bruce Upchurch	Terry Graham	None	None	
Department of Human Rights	Rose Vasquez, Director	Joan Moll	None	None	
Department of Human Services	Jessie Rasmussen, Director	Kate Walton			See Attachment 1
Information Technology Services	Rich Varn, Director	Tom Shepard	2	None	July 15 15, 2000 - Lt. Governor Sally J. Pederson Accessibility survey of the Hoover Building. Found a standard doorknob between data entry and software support area. Recommended installing a lever action handle to comply with 4.13.9 of the ADAAG.

Attachment E

FY 2001 *(continued)*					
FACILITY NAME: Woodward Resource Center					
Date citation issued	**Regulatory agency issuing citation**	**Citation received**	**Circumstances regarding violation**	**Corrective action taken**	**How services were or will be affected due to corrective action**
	DIA	W164 – PROFESSIONAL PROGRAM SERVICES Each client must receive the professional program services needed to implement the active treatment program defined by each client's individual program plan.	Annual Survey	See attached Plan of Correction	Implementation of the revised consent process continued
	DIA	W263 – PROGRAM MONITORING NAD CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.	Annual Survey	See attached Plan of Correction	Implementation of the revised consent process continued
	DIA	W362 – DRUG REGIMEN REVIEW A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly.	Annual Survey	See attached Plan of Correction	An improved process was put in place to ensure pharmacy reviews were done timely.
4-26-01	DIA	W124 – PROTECTION OF CLIENTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.	Complaint	See attached Plan of Correction	Implementation of the revised consent process continued
	DIA	W285 –MANAGEMENT OF INAPPROPRIATE CILENT BEHAVIOR Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected.	Complaint	See attached Plan of Correction	Changes are being made in policies and staff training on management of inappropriate client behavior.
6-22-01	DIA	W369 DRUG ADMINISTRATION The system must assure that all drugs, including those that are self-administered, are administered without error.	Complaint	See attached Plan of Correction	An individual was retrained, and a process is being implemented to monitor medication passing and ensure accuracy.
4-4-01	State Fire Marshal	See attached. Annual inspection citing minor violations of State Fire Marshal regulations	Examples would be of the hundreds of doors in our facility, a few were found that didn't latch properly and swung shut; staff or clients forgetting to keep routes of egress free of obstruction.	Plans of correction were given to have corrections made within 6 months and that was done.	Services were minimally affected
5-16-01	Division of Labor	See attached. Annual inspection citing minor violations of Division of Labor regulations	Examples would be minor adjustments required to steam pressure vessels throughout the campus.	Corrections were all made within 6 months.	Services were not affected; however, if corrections were not made, we would not have been issued a certificate to operate the particular vessel being cited.
5-17-01	Division of Labor	See attached. Annual inspection citing minor violations of Division of Labor regulations	Examples would be minor adjustments required to steam pressure vessels throughout the campus.	Corrections were all made within 6 months.	Services were not affected; however, if corrections were not made, we would not have been issued a certificate to operate the particular vessel being cited.
6-5-01	Division of Labor	See attached. Annual inspection citing minor violations of Division of Labor regulations	Examples would be minor adjustments required to steam pressure vessels throughout the campus.	Corrections were all made within 6 months.	Services were not affected; however, if corrections were not made, we would not have been issued a certificate to operate the particular vessel being cited.

PART TWO: **Fill in the following three tables:**

FY 1999					
FACILITY NAME: Woodward Resource Center					
Date decertified or threat of de-certification issued	**Regulatory agency issuing de-certification**	**Circumstances regarding de-certification or threat of de-certification**	**Corrective action taken**	**How de-certification will affect services**	**How services were or will be affected due to corrective action**
July 15, 1998	DIA	Death of individual	See citations of 9/21/98 revisit	Not decertified, Immediate and Serious Threat eliminated August 3, 1998—Conditions of Participation in compliance November 17, 1998	Improved safety by making changes in policies, practices, supervision, staff training, and mechanical systems
	State Fire Marshal	No decertifications			
	Dept. of Labor	No decertifications			

ATTACHMENT 2

IOWA DEPARTMENT OF CORRECTIONS

Facility Name	DATE CITATION ISSUED	CITATION RECEIVED	CIRCUMSTANCES REGARDING VIOLATION	CORRECTION ACTION TAKEN	HOW SERVICES WERE OR WILL BE AFFECTED DUE TO CORRECTIVE ACTION
Anamosa State Penitentiary	None Reported				
Fort Dodge Correctional Facility	None Reported				
Newton Correctional Facility	DNR Waste Water Permit Section 3/29/01	Discharge from Waste Water Treatment Facility exceeded limits.	CBOD Limitation exceeded because Lagoon system needs replaced.	The Governor's Vertical Infrastructure Advisory Committee(VIAC) funded design ($63,000) in FY'01 and new construction in FY '02 ($750,000).	Removal of lagoons. Waste water will be sent to City of Newton for treatment.
Clarinda Correctional Facility	DNR 8/24/2000	Nitrate violations at S/EP02.	Agriculture nitrate run off. Also, water pressure problems.	Construction of a new water tower and well with VIAC Funds. Construction is scheduled to begin Fiscal year '02 at a cost of $1,430,000.	Water production remains with State at a normal nitrate/arsenic level for use.
Iowa Correctional Institution for Women	None Reported				
Iowa Medical and Classification Center	OSHA 2/4/1999	Guard tower (cleanliness), Fire Alarm, Pests, Lack of hot/cold water.		Providing better pest control, installing fire alarm, replumbing facility, issuing memo to employees about eating and drinking in the tower.	No change in scope of services given.
	Labor Commissioner 11/1/1998	Boiler Inspection.		Replaced safety valves, repaired D-tubes, repair or replace steam stop valve.	No change in scope of services given.
Iowa State Penitentiary	DNR Aug.22,2000		Citation for having too high of a level of copper in drinking water. The action level of copper in drinking water is 1.3 mg/L. ISP's water levels tested at 1.7mg/L.	Lowered chlorine to keep PH level down, to prvent chlorine from damaging the copper pipes. A Public Notice Health concern was published. Subsequent samples were under the action level.	By passing subsequent water tests, services are not affected. However, an expensive treatment process would have had to be implemented if copper samples continued to exceed the limits.
	State Fire Marshall: June 23,2000 Aug. 13,1999 July 13, 1998		As part of the Fire Marshall's annual inspections several items of non-compliance must be corrected.	Low cost items are corrected in house. Major items are being addressed with FY'01 $1.25M and FY'02 $1.5M VIAC Funds.	Cellhouse 17 and the auditorium have been closed to occupancy.

IOWA DEPARTMENT OF CORRECTIONS

Facility Name	DATE CITATION ISSUED	CITATION RECEIVED	CIRCUMSTANCES REGARDING VIOLATION	CORRECTION ACTION TAKEN	HOW SERVICES WERE OR WILL BE AFFECTED DUE TO CORRECTIVE ACTION
Iowa State Penitentiary	DNR - Oct. 27,1998 April 9,1999 April 2, 2001		The DNR requires the treatment of sewage prior to discharge into waterways. The Farm 1 septic tanks possibly discharged into a pasture ditch for about 48 years prior to the Notice of Violation by DNR.	In June,2000, a sand filter was constructed in an effort to comply. The sand filter was not satisfactory and the DNR required that the septic tank be pumped 3 times weekly and the sewage disposed at a treatment plant. Eventually the Farm 1 dormitory sewer system will be connected to the City of Ft. Madison sewer system.	Less funding is available for other maintenance projects because so much was expended for the corrective actions ($51,000 to date). Eventually the Farm 1 sewer will be connected to the City of Ft. Madison's sewer system and a usage fee will begin which was not budgeted.
	DNR 5/01/00		Responding to a complaint, the DNR found that fruit bags ashes and construction debris had been dumped in a ravine at Farm 1.	The improperly disposed material was taken to the landfill or the local scrap metal business.	None other than labor and vehicle expense.
Mt.Pleasant Correctional Facility	State Fire Marshall 5/19/2000	Notice to make corrections	Repairs on electrical wiring;light fixtures;leak;seal several holes around pipes;do some sheet rock work;upgrade dryer vent;secure main control valve;fix exposed live wires;some ceiling repair;unobstruct some exists;provide electro magnetic hold open for specific door.	Facility completed most issues. Balance will be resolved with VIAC project with FY '01 $1.034M and FY '02 $1.7M.	Improved safety throughout buildings.
	OSHA 7/12/00	Issues with volunteer fire brigade and equipment used when responding to fire/smoke.	Did not ensure employees using a tight-fitting face piece respirator were fit tested prior to use. Allowed use of masks by employees with facial hair. Two untrained employees performed fire brigade duties. Fire brigade not physically tested to perform duties. Did not provide necessary on-going training to fire brigade.	MPCF now has a contract with the City of Mt. Pleasant Fire Department to handle all fire calls.	Improved safety for all employees and offenders.
	DIA/HCFA 7/19/00	Non-compliance with Medicare certification.	Cleanliness of food service areas;pest control issues.	Daily inspections of all food areas; closely monitor/work with pest control.	Improved cleanliness throughout the institution.
	Iowa Division of Labor Services 5/31/2001	Asbestos abatement issues.	Employees were issued tyvack suits,boots,gloves and respirators to protect during asbestos abatement operations. Employer did not assess the work place for hazard determination.	Reviewed written asbestos abatement and added form for completion on all asbestos projects that includes written job hazard analysis. Training also was help with employees working with abatement.	Improved safety for employees working in asbestos abatement projects.
	DNR 6/26/01	We did not receive any written or formal citation, rather the inspector showed up unannounced. No documentation was left with us after his visit and as of this date we have not received any kind of report or citation notice.	Asbestos abatement had been done in an area by an outside contractor and there was a concern by DNR that there may be asbestos in the area.	Area was closed. Samples were taken and the area was recleaned prior to resuming construction operations.	We will continue with the renovation project. No interruption in services except for the 2 days the area was closed down.
	Iowa Division of Labor Services 7/2/01	Notified by phone on July 2, 2001 of alleged complaints. No citation issued.	Employees and inmates are allowed to smoke throughout the facility. Also, the smoke detectors have been shut off in the men's units.	Smoking has not been permited in the facility since October, 1995 except in the ambulance entrance and this area will become smoke-free effective July 10, 2001. The facility smoke detectors have remained operational since the initial installation of the system. There have been some issues with sensitivity and the concerns have been addressed with Siemens, the contractor who maintains the fire alarm system.	Facility totally smoke-free except for smoking outside of the buildings. All smoke detectors to remain operational upon inspection by Siemens, our contractor.
North Central Correctional Facility	None Reported				
Central Office	None Reported				