December 10, 2015

Gerald Marshall, Chief
Delano Modified Community Correctional Facility
2727 West Industry Way
Delano, CA, 93216

Dear Chief Marshall:

The staff from Private Prison Compliance and Monitoring Unit (PPCMU), Field Operations, Corrections Services, California Correctional Health Care Services (CCHCS) completed an onsite Corrective Action Plan (CAP) Review at Delano Modified Community Correctional Facility (DMCCF) on November 2, 2015. The purpose of the CAP Review is to assess and measure your facility's compliance with the areas and processes that were identified to be deficient at the time of the previous health care audit conducted at your facility on March 3, 2015.

Attached you will find the CAP Review report which lists all the CAP items that were identified during the previous health care audit along with a brief narrative describing the facility's progress towards the resolution of each deficiency. The findings of the CAP Review reveal that DMCCF was able to effectively resolve 21 of 29 CAP items, with 8 remaining outstanding.

The frequent turn-over in facility health care staff, inability to hire and retain a 40 hour/5 days per week primary care provider (PCP) and the following unresolved deficient items create grave concern for the well being of the patient population housed at this facility and require facility's immediate attention and resolution:

- The PCP does not consistently review, initial and date an patient's diagnostic reports within two days of receipt.
- MCCF medical charts continue to lack documentation of the MCCF RN signing and dating the CDCR 7371, *Health Care Transfer information* Form for newly arrived patients.
- The facility's nursing staff continue to fail to document on an Interdisciplinary Progress Note that they conducted a face-to-face evaluation of the inmate patient upon his return from a community hospital emergency department.
- The Emergency Medical Response Review Committee meeting minutes do not discuss deficiencies identified or areas for improvement.
- The facility's emergency medical drill documentation continues to lack evidence that the drill was analyzed or discussed; nor was there discussion of the outcome/effectiveness of the medical care rendered.

The lack of 40 hour/5 days per week PCP coverage and poor documentation practices pose a great risk to the mortality and well being of the patient population

housed at this facility. All of the unresolved critical issues are correctable and within the management's scope of control to ensure compliance. The Chief must make the resolution of these critical items a priority, holding American Correctional Care Solutions responsible for hiring health care staff and managing the health care functions within this facility.

Thank you for your assistance and please extend my gratitude to your staff for their professionalism and cooperation during this onsite visit. Should you have any questions or concerns, you may contact Donna Heisser, Health Program Manager II, PPCMU, Field Operations, Corrections Services, CCHCS, at (916) 691-4849 or via email at Donna.Heisser@cdcr.ca.gov.

Sincerely,
Donald Meier, Deputy Director
Field Operations, Corrections Services
California Correctional Health Care Services

Enclosure

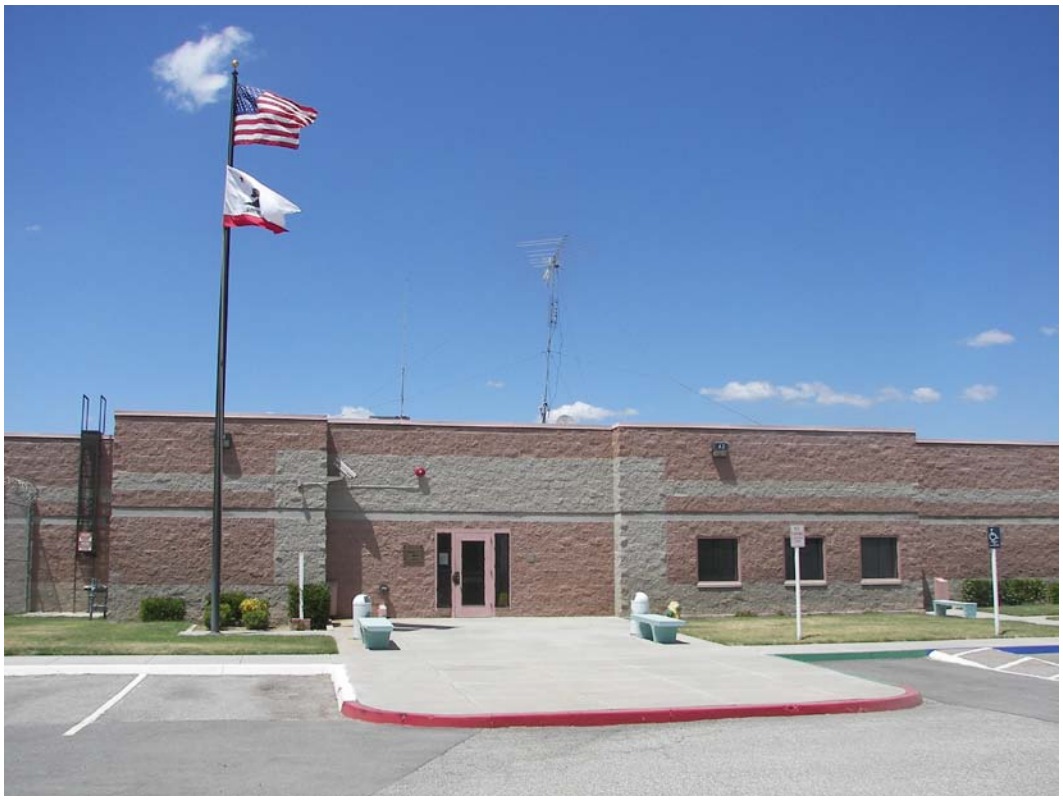
cc: Richard Kirkland, Chief Deputy Receiver, CCHCS
Diana Toche, Undersecretary, Health Care Services, California Department of Corrections and Rehabilitation (CDCR)
R. Steven Tharratt, M.D., M.P.V.M., F.A.C.P., Director, Health Care Operations, CCHCS
John Dovey, Director, Corrections Services, CCHCS
Kelly Harrington, Director, Division of Adult Institutions (DAI), CDCR
Ricki Barnett, M.D., Assistant Statewide Medical Executive and Deputy Director, Medical Services, CCHCS
Jeffrey Carrick, M.D., Deputy Medical Executive, Utilization Management, CCHCS
Roscoe L. Barrow, Chief Counsel, CCHCS
Cheryl Schutt, Statewide Chief Nurse Executive, Nursing Services, CCHCS
Jay Virbel, Associate Director, Female Offender Programs and Services/Special Housing, DAI, CDCR
Joseph W. Moss, Chief (A), Contract Beds Unit, California Out of State Correctional Facility, DAI, CDCR
Michael J. Williams, Chief Deputy Administrator, Contract Beds Unit, COCF, DAI, CDCR

Linda Wong, Manager, Office of Audits and Court Compliance, CDCR
Steven Moulios, D.O., Physician Advisor, Central Region, Utilization Management, CCHCS
Joseph Williams, Correctional Administrator, Field Operations, Corrections Services, CCHCS
Luzviminda Pareja, Nurse Consultant, Program Review, PPCMU Field Operations, Corrections Services, CCHCS
Patricia Matranga, R.N., Nursing Services, CCHCS
Donna Heisser, Health Program Manager II, PPCMU, Field Operations, Corrections Services, CCHCS
Susan Thomas, HPS I, PPCMU, Field Operations, Corrections Services, CCHCS

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

# CONTRACT FACILITY HEALTH CARE MONITORING AUDIT

## Corrective Action Plan Review



## Delano Modified Community Correctional Facility

November 2, 2015

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## DATE OF REPORT

**December 10, 2015**

## INTRODUCTION

As a result of an increasing inmate population and a limited capacity to house inmates, the California Department of Corrections and Rehabilitation (CDCR) entered into contractual agreements with private prison vendors to house California inmates. Although these inmates are housed in a contracted facility, either in or out-of-state, the California Correctional Health Care Services (CCHCS) is responsible to ensure health care standards equivalent to California's regulations, CCHCS's policy and procedure, and court ordered mandates are provided.

As one of several means to ensure the prescribed health care standards are provided, CCHCS staff developed a tool to evaluate and monitor the delivery of health care services provided at the contracted facility through a standardized audit process. This process consists of a review of various documents obtained from the facility; including medical records, monitoring reports, staffing rosters, and other relevant health care documents, as well as an onsite assessment involving staff and inmate interviews and a tour of all health care services points within the facility.

This report provides the findings associated with the Corrective Action Plan (CAP) review conducted on November 2, 2015, at Delano Modified Community Correctional Facility (DMCCF), which is located in Delano, California. At the time of the audit, CDCR's *Weekly Population Count*, dated October 30, 2015, indicated that DMCCF had a design capacity of 578 beds, of which 531 were occupied with CDCR inmates.

## EXECUTIVE SUMMARY

On November 2, 2015, the CCHCS audit team conducted a CAP Review at DMCCF. The audit team consisted of the following personnel:

P. Matranga, Registered Nurse
D. Heisser, Health Program Manager II
S. Thomas, Health Program Specialist I

CCHCS was in the final development stages of completing the *Private Prison Compliance and Health Care Monitoring Audit Instruction Guide* during the time the compliance monitoring audit was scheduled to be conducted at DMCCF. The decision was made to conduct a CAP review in lieu of a comprehensive audit in order to complete the vetting process and to introduce the Modified Community Correctional Facilities (MCCF) executive staff to the new audit instrument and the changes to the methodology. Utilizing the new audit instrument without informing the MCCFs was not a consideration, as their lack of knowledge of the details included in the new guide, would have contributed to the MCCFs inability to meet the new expectations.

On October 1, 2015, CCHCS hosted an onsite meeting with the MCCF executives, during which time, a draft version of *Private Prison Compliance and Health Care Monitoring Audit Instruction Guide* was provided to the MCCF executive staff. The purpose of the meeting was to educate and provide insight to each MCCF executive staff member on CCHCS' expectations relating to the health care provided to CDCR patients housed at their facilities. CCHCS also wanted to afford the MCCFs an opportunity to clarify their understanding of the CCHCS health care delivery standards and discuss any issues or concerns regarding the methodologies listed in the new audit guide. The meeting was successful and the MCCFs were fully informed of the new audit instrument and program expectations. This mutual interaction was a show of good faith on behalf of CCHCS to provide the MCCFs with the knowledge and tools necessary to improve their overall performance during subsequent audits. The finalized version of the audit guide was distributed to the MCCFs on October 5, 2015.

It should be noted that there were numerous changes to the *Inmate Medical Services Policies and Procedures* (IMSP&P) that require the MCCFs to draft new policies or update their existing policies and procedures based on the changes. Additionally, the MCCFs are expected to provide training to all their health care staff on the new and updated requirements by the time of their next onsite health care monitoring audit, and as needed thereafter, and ensure staff's compliance with the policies and requirements.

During the CAP review process, the auditors conducted a brief assessment of all areas and processes that were identified to be deficient at the time of the previous monitoring audit conducted at DMCCF on March 3, 2015. The deficient items included findings obtained from medical record reviews, pre-audit documentation reviews and onsite observations and interviews. Based on the type of CAP issue being reviewed, the auditors utilized the same methodology that was initially used to determine compliance with a specific standard/requirement. This helped the auditors maintain consistency during the reviews.

## METHODOLOGY

The auditors predominantly utilized three methods to evaluate compliance during the CAP Review process:

i. Medical Record Reviews: All items that were previously found to be deficient following the health record reviews are evaluated by the nurse auditors. Auditors review five patient health records for each CAP item and compliance is determined based on the documentation found in the medical records. This review is completed both remotely by reviewing the electronic Unit Health Records and by an onsite review of the MCCF shadow files. The issues are determined to be resolved ONLY if <u>all</u> five records reviewed are compliant with the requirement. The issue is considered to be unresolved even if one out of five records is found to be deficient.

ii. Document Review: The administrative items that were previously identified to be deficient related to the facility's lack of policies and procedures, absence of training logs, absence of mechanism to track release of information, health care appeals, licenses and certifications, and contracts are evaluated by the Health Program Specialists (HPS I). The facilities are requested to submit the pertinent documentation to Private Prison Compliance and Monitoring Unit (PPCMU) prior to the

onsite CAP reviews. The HPS Is review the documents received from the MCCF and determine compliance.

iii. Onsite observations and interviews with MCCF staff: The CAP items previously identified as a result of onsite inspections and observations of facility's various medical processes and staff interviews are evaluated during the onsite visit. The nurse and HPS I auditors conduct inspections of various clinical and housing areas within the facility, interview key facility personnel which includes medical staff for the overall purpose of evaluating compliance of the identified issues and to identify any new issues.

Table 1.1 below lists the total number of CAP items that were identified in each chapter during the previous monitoring audit, and the total number of CAP items that were found to be resolved and unresolved during the CAP Review process.

Table 1.1

| DMCCF CAP Review – November 3, 2015 | | | |
|---|---|---|---|
| **Chapter** | **Total Number of CAP Items Identified** | **Number of Resolved Items** | **Number of Unresolved Items** |
| 1. Administration | 3 | 2 | 1 |
| 2. Access to Health Care | 1 | 0 | 1 |
| 3. Continuous Quality Improvement (CQI) | 2 | 2 | 0 |
| 4. Diagnostic Services | 1 | 0 | 1 |
| 5. Medical Emergency Services/Drills | 5 | 2 | 3 |
| 6. Medical Emergency Equipment | 7 | 7 | 0 |
| 7. Grievance/Appeal Procedure | 1 | 0 | 1 |
| 8. Infection Control | 2 | 2 | 0 |
| 9. Initial Intake Screening/Health Appraisal | 2 | 1 | 1 |
| 10. Medication Management | 3 | 3 | 0 |
| 11. Sick Call | 1 | 1 | 0 |
| 12. Specialty/Hospital Services | 1 | 1 | 0 |
| **Overall** | **29** | **21** | **8** |

The CAP items found unresolved during this CAP review process will remain active and will be monitored in subsequent audits. Each unresolved deficiency will require the MCCF to take the necessary action to bring the deficiency into compliance and will be re-examined during the facility's next scheduled health care audit.

Table 1.2 on the following page lists all new critical issues identified during the CAP Review process and Table 1.3 lists all the outstanding critical issues from the previous audit that remain unresolved.

## LIST OF NEW CRITICAL ISSUES IDENTIFIED DURING THE CAP REVIEW

Table 1.2

| Operational Area | Identified Critical Issue(s) |
|---|---|
| N/A | There were no new critical issues identified during the CAP Review process. |

## IDENTIFIED AND OUTSTANDING CRITICAL ISSUES – DMCCF

Table 1.3

| Chapter/Question | Unresolved Critical Issues |
|---|---|
| Chapter 1, Question 5 | The facility does not have a written policy that addresses the requirements for the release of medical information. |
| Chapter 8, Question 5 | The nursing staff do not document on the Interdisciplinary Progress Notes to show that a face-to-face evaluation of the patient was completed upon his return from a community hospital emergency department. |
| Chapter 8, Question 8 | The facility's EMRRC meeting minutes do not indicate the committee discussed and/or implemented a quality improvement action after reviewing the results of emergency medical responses and/or drills. |
| Chapter 8, Question 11 | The facility's emergency medical drill documentation reflects medical emergency scenarios, but does not document the drill participants or outcome/effectiveness of the medical care rendered. |
| Chapter 10, Question 1 | The facility's patient handbook does not explain the health care appeal process. |
| Qualitative Action Item #2 (Chapter 7, Question 2) | The PCP does not consistently review, initial and date an patient's diagnostic reports within two days of receipt. |
| Qualitative Action Item #5 (Chapter 12, Question 10) | The MCCF RN does not consistently sign and date the CDCR 7371, Health Care Transfer Information Form. |

*NOTE: A discussion of the facility's progress toward resolution of all CAP items identified during previous audit is included in the CAP Item Review portion of this report.*

## CAP ITEM REVIEW

The Contract Facility Health Care Monitoring Audit, conducted at DMCCF on March 3, 2015, resulted in the identification of 22 quantitative and 7 qualitative CAP items. During the CAP review audit, auditors found 21 of the 29 items resolved, with the remaining 8 unresolved within acceptable standards.

1. Question 1.5 – THE FACILITY DOES NOT HAVE A WRITTEN POLICY THAT ADDRESSES THE REQUIREMENTS FOR THE RELEASE OF MEDICAL INFORMATION.

| Prior Compliance | Current Compliance | Status |
|---|---|---|
| 0.0% | 0.0% | **Unresolved** |

During the previous audit, the facility did not have a written policy in place addressing the requirements for the release of medical information. During the CAP Review, the auditors were supplied the facility's written policy for the release of medical information. The policy does not address what information is required to be tracked on the release of information log. DMCCF has failed to resolve this issue; therefore, this item is considered unresolved and will be evaluated and monitored during subsequent audits.

2. Question 1.8 – THE FACILITY'S WRITTEN POLICY FOR CHRONIC CARE IS NOT COMPLIANT WITH IMSP&P.

| Prior Compliance | Current Compliance | Status |
|---|---|---|
| 0.0% | 100% | **Resolved** |

The previous audit findings showed that the facility's written Chronic Care policy was not in compliance with the requirements in the *Inmate Medical Services Policies & Procedures* (IMSP&P). As part of the documentation production process for the current audit, the auditors were provided an updated copy of the facility's Chronic Care policy and found it to be in compliance with the requirements in the IMSP&P. The findings show that DMCCF has successfully addressed this deficiency, this item is considered resolved.

3. Question 1.17 – THE FACILITY DOES NOT HAVE A WRITTEN POLICY RELATED TO LICENSURE AND TRAINING.

| Prior Compliance | Current Compliance | Status |
|---|---|---|
| 0.0% | 100.0% | **Resolved** |

The findings of the March 2015 audit showed the facility did not have a written policy in place related to licensure and training. As part of the documentation production process for the current audit, the facility provided the audit team with a written policy which addressed the requirements for licensure and RN training/orientation at the hub facility. The CAP Review process utilizes the same methodology to assess compliance as previous audits and the facility was able to meet those established standards, this CAP item is considered resolved.

4. Question 6.1 – THE FACILITY DOES NOT HAVE AN APPROVED CONTINUOUS QUALITY IMPROVEMENT (CQI) PLAN.

| Prior Compliance | Current Compliance | Status |
|---|---|---|
| 0.0% | 100% | **Resolved** |

The audit team found the facility did not have an approved CQI Plan in place during the previous audit. During the current review, the facility provided the audit team with a copy of the CQI Plan in compliance with the standards established in previous audits. The findings show that DMCCF has successfully addressed this deficiency, this item is considered resolved.

5. Question 6.3 – THE FACILITY DOES NOT HOLD CQI MEETINGS QUARTERLY.

| Prior Compliance | Current Compliance | Status |
|---|---|---|
| 0.0% | 100.0% | **Resolved** |

The findings of the previous audit reflected the facility was not holding CQI meetings quarterly. During the pre-audit documentation review process for the CAP Review, the auditors reviewed the facility's CQI meeting minutes submitted for April through September, 2015. The audit team found the facility is currently holding CQI meetings every month. The auditors also gave suggestions on how to improve the current CQI meeting minutes. The findings show that DMCCF has successfully addressed this deficiency, this item is considered resolved.

6. Question 8.5 – THE NURSING STAFF DO NOT DOCUMENT ON THE INTERDISCIPLINARY PROGRESS NOTE TO SHOW THAT A FACE-TO-FACE EVALUATION OF THE PATIENT WAS COMPLETED UPON HIS RETURN FROM A COMMUNITY HOSPITAL EMERGENCY DEPARTMENT.

| Prior Compliance | Current Compliance | Status |
|---|---|---|
| 0.0% | 50.0% | **Unresolved** |

During the previous audit, five patient medical files were reviewed for compliance. The auditor found that documentation was completed on an Intake Screening Form instead of the Interdisciplinary Progress note when nursing staff completed a face-to-face (FTF) evaluation upon the patient's return from a community hospital emergency department. During the CAP Review, there were only four patients who were sent to the community hospital emergency department. Of the four medical files reviewed for compliance, two were found non-compliant with this requirement. There was no documentation showing the RN completed a FTF evaluation upon the patient's return to the facility. All four medical records reviewed are required to be in compliance with this standard; therefore, this deficiency is considered unresolved and will continue to be monitored during subsequent audits.

7. Question 8.7 – THE FACILITY'S EMERGENCY RESPONSE REVIEW COMMITTEE (ERRC) DOES NOT MEET AT LEAST ONCE A MONTH.

| Prior Compliance | Current Compliance | Status |
|---|---|---|
| 0.0% | 100% | **Resolved** |

The findings of the March 2015 audit showed the facility did not hold monthly Emergency Medical Response Review Committee (EMRRC) meetings, resulting in 0.0% compliance. As part of the documentation production process for the current audit, the facility provided the EMRRC meeting minutes for the past four months. The review of the submitted documentation reflects the EMRRC meetings are now being held monthly by the facility. The findings show that DMCCF has successfully addressed this deficiency, this item is considered resolved.

8. Question 8.8 – THE FACILITY'S EMRRC MEETING MINUTES DO NOT INDICATE THE COMMITTEE DISCUSSED AND/OR IMPLEMENTED A QUALITY IMPROVEMENT ACTION AFTER REVIEWING THE RESULTS OF EMERGENCY MEDICAL RESPONSES AND/OR DRILLS.

| Prior Compliance | Current Compliance | Status |
|---|---|---|
| 0.0% | 0.0% | **Unresolved** |

The EMRRC meeting minutes, submitted during the previous audit, did not indicate the committee discussed and/or implemented a quality improvement action after reviewing the results of emergency medical responses and/or drills, resulting in 0.0% compliance. During the pre-audit documentation review process for the current audit, the audit team assessed the EMRRC meeting minutes provided by the facility for the past four months. The EMRRC meeting minutes do not discuss deficiencies identified or areas for improvement. The auditors discussed the need for the meeting minutes to reflect any deficiencies identified and areas requiring improvement. The findings show that DMCCF has failed to address this issue; therefore, this deficiency is considered unresolved and will continue to be monitored during subsequent audits.

9. Question 8.10 – THE FACILITY DOES NOT DOCUMENT THE RESPONSE TIMES OF BASIC LIFE SUPPORT (BLS) CERTIFIED MEDICAL STAFF DURING EMERGENCY MEDICAL RESPONSE AND/OR DRILLS.

| Prior Compliance | Current Compliance | Status |
|---|---|---|
| 0.0% | 100% | **Resolved** |

The March 2015 audit findings reflected the facility failed to document the response times of BLS certified medical staff during emergency medical responses and/or drills, resulting in 0.0% compliance. During the current audit, the facility provided the audit team with documentation addressing the emergency response/drills, all of which documented the response times of the BLS certified staff. The findings show that DMCCF has successfully addressed this deficiency, this item is considered resolved.

10. Question 8.11 – THE FACILITY'S EMERGENCY MEDICAL DRILL DOCUMENTATION REFLECTS MEDICAL EMERGENCY SCENARIOS, BUT DOES NOT DOCUMENT THE DRILL PARTICIPANTS OR OUTCOME/EFFECTIVENESS OF THE MEDICAL CARE RENDERED.

| Prior Compliance | Current Compliance | Status |
|---|---|---|
| 0.0% | 0.0% | **Unresolved** |

The findings of the previous audit reflected the facility's Emergency Medical Response/Drill documentation did not document the drill participants or the outcome/effectiveness of the medical care rendered, resulting in 0.0% compliance. During the CAP Review, the audit team reviewed the Emergency Medical Response Drill documentation. The documentation continued to lack evidence the drill was analyzed or discussed; nor was there discussion of the outcome/effectiveness of the medical care rendered. The findings show that DMCCF has failed to address this issue; therefore, this deficiency is considered unresolved and will continue to be monitored during subsequent audits.

11. Question 9.1 – EMERGENCY RESPONSE BAGS ARE NOT BEING INSPECTED ON EACH SHIFT TO ENSURE THE SEAL IS SECURE.

| Prior Compliance | Current Compliance | Status |
|---|---|---|
| 0.0% | 100% | **Resolved** |

During the previous audit's onsite visit, it was found the facility failed to document that the Emergency Response Bags were being inspected on each shift to ensure the seal is secure, resulting in 0.0% compliance. During the current onsite visit, the audit team reviewed the Emergency Response Bag Inspection checklist which documented the nursing staff is inspecting the seal on each shift. The findings show that DMCCF has succeeded in addressing this deficiency, this item is considered resolved.

12. Question 9.2 – THERE IS NO DOCUMENTATION THAT THE EMERGENCY MEDICAL RESPONSE BAG IS RESUPPLIED AND RESEALED AFTER EACH MEDICAL EMERGENCY.

| Prior Compliance | Current Compliance | Status |
|---|---|---|
| 0.0% | 100% | **Resolved** |

The March 2015 onsite audit findings showed the facility failed to document that the Emergency Response Bag is being resupplied and resealed after each medical emergency, resulting in 0.0% compliance. During the current onsite visit, the audit team reviewed the Emergency Response Bag Inspection checklist which documented the nursing staff is resupplying and resealing the Emergency Response Bag after each medical emergency. The findings show that DMCCF has successfully addressed this deficiency, this item is considered resolved.

13. Question 9.3 – THE FACILITY DOES NOT HAVE A PORTABLE SUCTION DEVICE IN THEIR MEDICAL CLINIC.

| Prior Compliance | Current Compliance | Status |
|---|---|---|
| 0.0% | 100% | **Resolved** |

The facility was found missing a portable suction device during the March 2015 onsite visit. While conducting the current onsite CAP Review, the nurse auditor verified that the facility's portable suction device was onsite and functional. The findings show that DMCCF has successfully addressed this deficiency, this item is considered resolved.

14. Question 9.6 – THE OXYGEN TANK IS NOT CHECKED ON EVERY SHIFT FOR OPERATIONAL READINESS.

| Prior Compliance | Current Compliance | Status |
|---|---|---|
| 0.0% | 100% | **Resolved** |

During the March 2015 onsite audit, it was found the facility failed to document the oxygen tank is checked on every shift for operational readiness, resulting in 0.0% compliance. During the current onsite audit, the audit team reviewed the oxygen tank log and observed the nursing staff checking the oxygen tank on every shift for operational readiness. DMCCF has successfully addressed this deficiency, this item is considered resolved.

15. Question 9.8 – THERE IS NO DOCUMENTATION THAT THE AUTOMATED EXTERNAL DEFIBRILLATOR (AED) IS CHECKED EVERY SHIFT FOR OPERATIONAL READINESS.

| Prior Compliance | Current Compliance | Status |
|---|---|---|
| 0.0% | 100% | **Resolved** |

The previous onsite audit findings showed that the facility failed to document the AED is checked on every shift for operational readiness, resulting in 0.0% compliance. During the current onsite CAP Review, the audit team reviewed the AED log and observed the nursing staff checking the AED on every shift for operational readiness. The findings show that DMCCF has succeeded in addressing this deficiency, this item is considered resolved.

16. Question 9.10 – THE FACILITY'S FIRST AID KITS DID NOT CONTAIN ALL THE REQUIRED ITEMS (TAPE & RESUSCITATION MASKS).

| Prior Compliance | Current Compliance | Status |
|---|---|---|
| 0.0% | 100% | **Resolved** |

During the previous audit, the facility's first aid kits did not contain all the required items, resulting in 0.0% compliance. During the onsite CAP Review, the audit team inspected a sampling of first aid kits and found they contained all the required items. DMCCF has successfully addressed this deficiency, this item is considered resolved.

17. Question 9.11 – THE FACILITY DOES NOT HAVE SPILL KITS IN ALL THE DESIGNATED AREAS OF THE FACILITY.

| Prior Compliance | Current Compliance | Status |
|---|---|---|
| 62.5% | 100% | **Resolved** |

The facility was found missing three spill kits in eight of the required locations during the March 2015 onsite inspection, resulting in 62.5% compliance. During the current onsite inspection, the audit team found all spill kits in their required locations. DMCCF has successfully addressed this deficiency, this item is considered resolved.

18. Question 10.1 – THE FACILITY'S PATIENT HANDBOOK DOES NOT EXPLAIN THE HEALTH CARE APPEAL PROCESS.

| Prior Compliance | Current Compliance | Status |
|---|---|---|
| 0.0% | 0.0% | **Unresolved** |

The findings of the previous audit showed the facility's patient orientation handbook minimally addressed the health care grievance/appeal process, lacking information regarding the second and third level health care appeal processes. During the pre-audit documentation review process for the current audit, the audit team found there were no revisions or updates made to this section of the handbook, resulting in 0.0% compliance. This issue was brought to the attention of the Chief of Corrections and facility Captain who assured the audit team this deficiency will be addressed immediately. DMCCF has failed to address this issue; therefore, this item is considered unresolved and will be evaluated and monitored during subsequent audits.

19. Question 14.2 – THE PCP DOES NOT CONSISTENTLY DOCUMENT THE PATIENT EDUCATION FOR NEWLY PRESCRIBED MEDICATIONS.

| Prior Compliance | Current Compliance | Status |
|---|---|---|
| 83.3% | 100% | **Resolved** |

Six patient medical files were reviewed for compliance during the March 2015 audit. Of the six cases reviewed, five medical files had documentation showing that the PCP had provided patient education for newly prescribed medication, resulting in 83.3% compliance. During the CAP Review, all five patient medical records reviewed for compliance included documentation the PCP had provided patient education for newly prescribed medication. DMCCF has successfully addressed this deficiency, this item is considered resolved.

20. Question 14.9 – THE REGISTERED NURSE (RN) DOES NOT CONSISTENTLY CHECK THE PATIENT'S MOUTH, HANDS AND CUP AFTER ADMINISTERING DIRECTLY OBSERVED THERAPY (DOT) MEDICATIONS.

| Prior Compliance | Current Compliance | Status |
|---|---|---|
| 0.0% | 100% | **Resolved** |

During the previous audit's onsite visit, the facility RN was observed not consistently checking the patient's mouth, hands, and cup after administering DOT medications, resulting in 0.0% compliance. During the current onsite visit, the facility had one patient who was taking DOT medication. The audit team observed the facility RN administer the DOT medication and check the patient's mouth, hands and cup after administering the medication. DMCCF has successfully addressed this deficiency; therefore, this item is considered resolved.

21. QUESTION 14.10 – THE PATIENTS DO NOT TAKE ALL KEEP ON PERSON (KOP) MEDICATIONS TO THE DESIGNATED RN PRIOR TO TRANSFER.

| Prior Compliance | Current Compliance | Status |
|---|---|---|
| 0.0% | 100% | **Resolved** |

During the March 2015 onsite audit, the facility RN reported that the patients did not take all their KOP medications to the designated RN prior to transfer, resulting in 0.0% compliance. During the current review, as there were no patients who transferred from the facility at the time of the onsite visit, this standard was assessed via the interview of nursing staff. The RN that was interviewed reported that patients currently bring their KOP medication to the night nurse prior to transfer. The night nurse then confirms the medication against the pharmacy profile. The findings show that DMCCF's nursing staff are knowledgeable on this process; therefore; this CAP item is considered resolved.

22. Question 19.6 – THE PCP DOES NOT CONSISTENTLY REVIEW THE CONSULTANT'S REPORT AND SEE THE PATIENTS RETURNING FROM SPECIALTY APPOINTMENTS FOR FOLLOW-UP WITHIN THE SPECIFIED TIME FRAME.

| Prior Compliance | Current Compliance | Status |
|---|---|---|
| 0.0% | 100% | **Resolved** |

During the previous audit, two patient medical files were reviewed for compliance. Of the two cases reviewed, one patient had not returned to MCCF. The medical file of the patient who returned to the facility did not have documentation that the PCP reviewed the consultant's report or saw the patient upon his return from the specialty consult appointment. During the CAP Review, one inmate patient had been referred for a qualifying specialty consult appointment. The medical file included documentation that the PCP reviewed the specialty consultant's report upon the patient's return to the MCCF. DMCCF has successfully addressed this deficiency; therefore, this item is considered resolved.

23. Qualitative Action Item #1 (Chapter 2, Question 8) – THE PATIENT'S WRITTEN REQUESTS FOR RELEASE OF HEALTH CARE INFORMATION ARE NOT NOTED IN THE PROGRESS NOTES OF THE PATIENT MEDICAL FILES.

| Status |
|---|
| **Unresolved** |

The findings of the previous audit reflected facility's health care staff was not documenting patients' written requests for release of health care information on a progress note, resulting in 0.0% compliance. During the current eUHR audit, the auditors reviewed the medical files of five patients who requested copies of their health care information after the March 2015 audit. None of the files had documentation of the release of information on a progress note, resulting in 0.0% compliance. It should be noted this question has been removed from the new audit instrument and will be closed out during the subsequent audit. Although this specific question has been removed from the new audit instrument, the requirement to file copies of the release of health care information form in the patient's medical file remains the same.

24. Qualitative Action Item #2 (Chapter 7, Question 2) – THE PCP DOES NOT CONSISTENTLY REVIEW, INITIAL AND DATE AN PATIENT'S DIAGNOSTIC REPORTS WITHIN TWO DAYS OF RECEIPT.

Status
**Unresolved**

This issue was initially identified during the August 2014 audit. During the March 2015 eUHR audit, four patient medical files were reviewed for compliance. Of the four files reviewed, three included documentation that the primary care provider had reviewed, initialed, and dated the patient's diagnostic reports within two days of receipt of results, resulting in 75.0% compliance. During the current review, five patient medical files were reviewed for compliance. Three medical files were found non-compliant with the requirement, resulting in 40.0% compliance. This represents a 35.0% percentage point decline in compliance. All five medical records reviewed are required to be compliant with the established standard; therefore, this deficiency is considered unresolved and will continue to be monitored during subsequent audits. The facility's management team is strongly encouraged to take immediate action to address and resolve this critical issue as it has been outstanding for the past 16 months.

25. Qualitative Action Item #3 (Chapter 11, Question 10) – THE FACILITY DOES NOT HAVE A SEPARATE STORAGE AREA FOR BIOHAZARD MATERIALS THAT IS LABELED AND LOCKED.

Status
**Resolved**

During the previous onsite inspection, the central storage area for biohazard material was found not labeled or locked and was inside the medical clinic storage room. During the CAP review onsite visit, the auditors noted the new central storage area had been moved to another location and was locked and labeled, resulting in 100% compliance. The findings show that DMCCF has successfully addressed this deficiency, this item is considered resolved.

26. Qualitative Action Item #4 (Chapter 11, Question 12) – THE FACILITY DOES NOT ACCOUNT FOR ALL SHARPS (NEEDLES, SCALPELS, ETC) AT THE END OF EACH SHIFT.

Status
**Resolved**

The March 2015 onsite audit, it was observed the health care staff did not account for all sharps (needles, scalpels, etc) at the end of each shift. Health care staff reconciled the sharps once a day, resulting in 0.0% compliance. During the current onsite visit, the auditor reviewed the facility's Sharps Count Log and observed the nursing staff reconciling the sharps at the end of each shift (twice a day). The findings show that DMCCF has successfully addressed this deficiency, this item is considered resolved.

27. Qualitative Action Item #5 (Chapter 12, Question 10) – THE MCCF RN DOES NOT CONSISTENTLY SIGN AND DATE THE CDCR 7371, HEALTH CARE TRANSFER INFORMATION FORM.

Status
**Unresolved**

During the previous audit's eUHR review, the nurse auditor assessed five patient medical files. Two of the five files reviewed did not include documentation of the MCCF RN signing and dating the CDCR 7371, *Health Care Transfer information* Form, resulting in 60.0% compliance. During the current eUHR audit, four patient medical files were reviewed for compliance. Two medical files were found non-compliant with this requirement as the CDCR 7371 form was not found in the eUHR, resulting in 50.0% compliance. This represents a 10.0 percentage point decline in compliance. Since all four medical records reviewed are required to be in compliance with this standard in order for the CAP item to be considered resolved, this critical issue is considered unresolved and will be evaluated during subsequent audits until resolved.

28. Qualitative Action Item #6 (Chapter 12, Question 12) – THERE WAS NO DOCUMENTATION THAT THE PATIENTS RECEIVED ORIENTATION REGARDING THE PROCEDURES ON HOW TO ACCESS HEALTH CARE DURING THE INITIAL INTAKE SCREENING.

Status
**Resolved**

During the previous audit, five patient medical files were reviewed for compliance. Of the five cases reviewed, not one included documentation reflecting the patients received orientation during the initial intake screening regarding the procedures on how to access health care, resulting in 0.0% compliance. During the CAP Review, five patient medical files were reviewed and all were found to be compliant with this requirement. The findings show that DMCCF has successfully addressed this deficiency, this item is considered resolved.

29. Qualitative Action Item #7 (Chapter 18, Question 7) – PATIENTS WHO WERE REFERRED TO THE HUB OR MCCF PCP BY THE MCCF RN WERE NOT CONSISTENTLY SEEN WITHIN THE SPECIFIED TIME FRAME.

Status
**Resolved**

Nine patient medical files were reviewed for compliance during the March 2015 eUHR audit. Of the nine cases reviewed, five medical files included documentation reflecting the patients who were referred to the Hub institution or MCCF PCP by the MCCF RN were not consistently seen within the specified time frame, resulting in 55.6% compliance. During the current eUHR audit, five patient medical files were reviewed and all were found to be compliant with this requirement. The findings show that DMCCF has successfully addressed this deficiency, this item is considered resolved.

*This CAP item is considered to be resolved based on the methodology and guidelines utilized during the previous health care audits. However, it should be noted that if the audit team was

to evaluate this CAP item based on the new audit methodology that was provided to the facility on October 5, 2015, the facility would have rated non-compliant on these requirements. Therefore, the facility is strongly encouraged to take immediate action and bring this CAP item into acceptable standard of compliance based on new audit methodology as these questions will be re-examined and monitored during the next scheduled audit.

## CONCLUSION

During the CAP Review process, the audit team found that DMCCF made considerable progress and resolved 21 out of 29 deficiencies identified in the previous audit conducted. However, the facility has eight outstanding critical CAP issues that require immediate attention and resolution. Specifically, during the chart review, the auditors found that PCP does not consistently review the diagnostic reports within two business days of facility's receipt of results. This has been a deficiency for more than 16 months. The deficiency is a direct result of the facility not having a PCP onsite five days per week. Since August 13, 2015, the facility has had PCP coverage only two to three days per week, providing 20 hours of coverage a week.

The auditors also found the PCP sometimes fails to document his review of the consultant's report and see the patients returning from specialty appointments for follow-up within the specified time frame. Additionally, during the chart review, the auditors found the nursing staff does not consistently document their review of the patient's discharge plan nor consistently complete face-to-face evaluation upon the inmate's return to the facility from the emergency department. The auditors also found the medical charts do not include documentation of the MCCF RN signing and dating the CDCR 7371, *Health Care Transfer information* Form for new patient arrivals. The resolution of these critical issues requires the facility's supervisors and managers to check the process on a daily basis and to hold staff accountable to ensure all necessary steps are being taken to bring these issues into full compliance.

At the conclusion of the onsite visit on Tuesday, November 3, 2015, the audit team met with the Chief of Corrections and the HSA to discuss the findings of the CAP Review and any outstanding CAP items. The audit team learned that since the March 2015 audit, the facility had several turnovers in their health care staffing. This provides a challenge for the facility to provide continuity of care as exiting staff rarely train the replacement staff. Additionally, the facility continues to have difficulty hiring and retaining a PCP to provide coverage at the facility five days per week. It should be noted, as of November 1, 2015, the city of Delano entered into a contract with American Correctional Care Solutions (ACS) to provide licensed health care services at DMCCF, which should help reduce the staffing turnover rate and provide some consistency in health care staffing at the facility.

It is evident that DMCCF has demonstrated the ability to make improvements based on the numerous resolved CAP items and should be commended for the effort all their staff has taken to improve and resolve the deficiencies. All of the unresolved critical issues are fixable and within the management's scope of control to ensure compliance. The Chief must make the resolution of these critical items a priority, holding ACS responsible for hiring health care staff and managing the health care functions within this facility.