November 19, 2015

Wanda Wilson, Warden
McFarland Female Community Reentry Facility
120 Taylor Avenue
McFarland, CA, 93250

Dear Warden Wilson,

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 McFarland Female Community Reentry Facility (FCRF) on November 4, 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 February 9-10, 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 FCRF was able to effectively resolve 26 of 36 CAP items, with 10 remaining outstanding.

Be advised each unresolved CAP item will require your facility to take necessary action to bring the deficiency into compliance as it will be re-examined during the subsequent audit. The FCRF is encouraged to work diligently in order to improve the quality of medical services provided to the CDCR inmate population and to expediently resolve the outstanding concerns and deficiencies identified in the attached report.

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
Roscoe L. Barrow, Chief Counsel, CCHCS
Cheryl Schutt, R.N., B.S.N., CCHP, 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
Grace Song, M.D., Physician Advisor, Southern Region, Utilization Management, CCHCS
Steven Moulios, D.O., Physician Advisor, Central Region, Utilization Management, CCHCS
Robin Harrington, Correctional Administrator, Female Offender Program and Services, CDCR
Joseph Williams, Correctional Administrator, Field Operations, Corrections Services, CCHCS
Greg Hughes, Nurse Consultant, Program Review, Field Operations, Corrections Services, CCHCS
Luzviminda Pareja, Nurse Consultant, Program Review, Field Operations, Corrections Services, CCHCS
Patricia Matranga, R.N., Nursing Services, CCHCS
Donna Heisser, Health Program Manager II, PPCMU, Field Operations, Corrections Services, CCHCS
Kala Srinivasan, HPS I, PPCMU, Field Operations, Corrections Services, CCHCS
Vera Lastovskiy, HPS I, PPCMU, Field Operations, Corrections Services, CCHCS
Christopher Troughton, HPS I, 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

McFarland Female Community Reentry Facility

November 4, 2015

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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 4, 2015, at McFarland Female Community Reentry Facility (FCRF), which is located in McFarland, California. At the time of the audit, CDCR's *Weekly Population Count*, dated October 30, 2015, indicated that FCRF had a design capacity of 300 beds, of which 265 were occupied with CDCR inmates.

EXECUTIVE SUMMARY

On November 4, 2015, the CCHCS audit team conducted a CAP review at FCRF. The audit team consisted of the following personnel:

P. Matranga, Registered Nurse
D. Heisser, Health Program Manager II
V. Lastovskiy, 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 FCRF. 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 inmate-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 FCRF on February 9 through 10, 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 Review: All items that were previously found to be deficient following the health record reviews are evaluated by the nurse auditors. Auditors review five inmate-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: Thee 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 Is). 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 observation 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 or unresolved during the CAP Review process.

Table 1.1

FCRF CAP Review – November 4, 2015			
Chapter	**Total Number of CAP Items Identified**	**Number of Resolved Items**	**Number of Unresolved Items**
1. Administration	3	3	0
2. Access to Health Care Information	2	2	0
3. ADA Compliance	3	3	0
4. Continuous Quality Improvement (CQI)	1	0	1
5. Diagnostic Services	2	1	1
6. Medical Emergency Services/Drills	4	2	2
7. Medical Emergency Equipment	1	1	0
8. Grievance/Appeal Procedure	1	0	1
9. Infection Control	4	4	0
10. Medication Management	4	3	1
11. Monitoring Logs	5	2	3
12. Specialty/Hospital Services	1	1	0
13. Qualitative Findings	5	4	1
Overall	**36**	**26**	**10**

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 Issue(s)
N/A	There were no new critical issues identified during the CAP Review process.

IDENTIFIED AND OUTSTANDING CRITICAL ISSUES – FCRF

Table 1.3

Chapter/Question	Unresolved Critical Issues
Chapter 6, Question 5	The Continuous Quality Improvement committee does not complete an analysis for each identified "opportunity for improvement" as listed on the *Aspects of Care Monitoring* form, or similar form.
Chapter 7, Question 2	The primary care provider does not consistently review, initial, and date all inmate-patient diagnostic test reports within the specified timeframe.
Chapter 8, Question 4	The facility's nursing staff does not consistently document the review of the inmate-patient's discharge plan upon inmate-patient's return to the facility from the community hospital emergency department.
Chapter 8, Question 5	The facility's nursing staff does not consistently document the face-to-face evaluation of inmate-patients upon their return to the facility from the community hospital emergency department.
Chapter 10, Question 1	The inmate orientation manual/handbook does not explain the health care grievance/appeal process in detail.
Chapter 14, Question 2	The primary care provider does not consistently document that the newly prescribed medication was explained to the inmate-patient.
Chapter 15, Question 2	Based on the specialty care monitoring log, the inmate-patients are not consistently seen within the specified time frames as set forth in the specialty care policy.
Chapter 15, Question 3	Based on the emergency/hospital services monitoring log, the Inmate-patients are not consistently seen within the specified time frames as set forth in the emergency/hospital services policy.
Chapter 15, Question 4	Based on the chronic care monitoring log, the Inmate-patients are not consistently seen within the specified time frames as set forth in the chronic care policy.
Qualitative Action Item #2 (Chapter 5, Question 1)	The inmate-patient's chronic care follow-up visits are not consistently completed within the 90-day or less timeframe, or as ordered by the treating primary care provider.

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 FCRF on February 9-10, 2015, resulted in the identification of 31 quantitative and 5 qualitative CAP items. During the CAP review audit, auditors found 26 of the 36 items resolved, with the remaining 10 not resolved 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%	100%	**Resolved***

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 facility provided the audit team with a written local operating procedure (LOP). Since 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.

2. Question 1.13 – THE FACILITY DOES NOT HAVE A WRITTEN POLICY AND/OR PROCEDURE RELATED TO SPECIALTY SERVICES.

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

During the previous audit, the facility did not have a written policy in place related to specialty services. During the CAP Review, the facility provided the audit team with a written LOP. Since 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.

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

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

During the previous audit, the facility did not have a written policy in place related to licensure and training. During the CAP Review, the facility provided the audit team with a written LOP. Since 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 2.1 – THE NURSE PRACTITIONER (NP) COULD NOT DEMONSTRATE HER ABILITY TO ACCESS THE ELECTRONIC UNIT HEALTH RECORD.

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

During the previous audit, the NP could not demonstrate her ability to access the electronic Unit Health Record (eUHR) system when requested by the audit team, resulting in 0.0% compliance. As the NP was no longer employed at FCRF during the CAP Review, the facility's medical doctor was assessed for compliance with this requirement. The facility's medical doctor was able to demonstrate access to the eUHR, resulting in 100% compliance. The findings during the re-audit show that FCRF has succeeded in addressing this deficiency in an effective manner; therefore, this item is considered resolved.

5. Question 2.4 – THE FACILITY'S RELEASE OF INFORMATION (ROI) LOG DOES NOT CONTAIN ALL THE REQUIRED INFORMATION.

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

During the previous audit, the facility's Release of Information (ROI) log was found missing required data fields such as: number of pages copied, number of pages withheld, amount inmate-patient was charged, date medical records were released to the inmate-patient, and the name and classification of the staff completing the request, resulting in 0.0% compliance. During the CAP Review, the facility's ROI log was found to contain all the required data fields. The findings during the re-audit show that FCRF has succeeded in addressing this deficiency in an effective manner; therefore, this item is considered resolved.

6. Question 3.4 – THE FACILITY DOES NOT HAVE A LOCAL OPERATING PROCEDURE THAT EXPLAINS PROVISION OF INTERIM ACCOMMODATION TO A DISABILITY PLACEMENT PROGRAM (DPP) INMATE-PATIENT WHILE AN APPLIANCE IS ORDERED, REPAIRED, OR IN THE PROCESS OF BEING REPLACED.

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

During the previous audit, the facility's DPP LOP did not address the provision of interim accommodation while a health care appliance is ordered, repaired, or in process of being replaced, resulting in 0.0% compliance. During the CAP Review, the facility provided the audit team with an LOP indicating the provision of interim accommodation. Since 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.

7. Question 3.5 – THE FACILITY DOES NOT HAVE A LOP DEFINING A PROCESS FOR ADDING TO OR REMOVING AN INMATE-PATIENT FROM A DPP LIST.

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

During the previous audit, the facility's DPP LOP did not address how the DPP inmate-patients will be added to and removed from a DPP list, resulting in 0.0% compliance. During the CAP Review, the facility provided the audit team with an LOP explaining the process. Since 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.

8. Question 3.6 – THE FACILITY DOES NOT HAVE AN LOP DEFINING THE REQUIREMENT TO ESTABLISH AND DOCUMENT EFFECTIVE COMMUNICATION BETWEEN HEALTH CARE STAFF AND INMATE-PATIENT DURING EACH CLINICAL ENCOUNTER.

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

During the previous audit, the facility did not have an LOP explaining how the facility will ensure and document the establishment of effective communication between health care staff and an inmate-patient during each clinical encounter, resulting in 0.0% compliance. During the CAP Review, the facility provided the audit team with an LOP explaining and defining the process. Since 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.

9. Question 6.5 – THE CONTINUOUS QUALITY IMPROVEMENT COMMITTEE DOES NOT COMPLETE AN ANALYSIS FOR EACH IDENTIFIED "OPPORTUNITY FOR IMPROVEMENT" AS LISTED ON THE *ASPECTS OF CARE MONITORING* FORM, OR SIMILAR FORM.

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

During the previous audit, a review of the Continuous Quality Improvement (CQI) meeting minutes indicated the facility does not complete an analysis for each identified opportunity for improvement, resulting in 0.0% compliance. During the CAP Review, CQI meeting minutes from three quarterly CQI meetings were reviewed. The meeting minutes indicate the CQI Committee did not complete analyses for three identified opportunities for improvement nor recommended an action plan to improve performance for any of the identified issues. Since FCRF has failed to address this issue in an effective manner, this item is considered to be unresolved. This critical issue will be evaluated during subsequent audits until resolved.

10. Question 7.2 – THE PRIMARY CARE PROVIDER DOES NOT CONSISTENTLY REVIEW, INITIAL, AND DATE ALL INMATE-PATIENT DIAGNOSTIC TEST REPORTS WITHIN THE SPECIFIED TIMEFRAME.

Prior Compliance	Current Compliance	Status
14.3%	80.0%	**Unresolved**

During the previous audit, seven inmate-patient medical files were reviewed for compliance. Of the seven files reviewed, only one included documentation that the primary care provider (PCP) had reviewed, initialed, and dated the inmate-patient's diagnostic reports within two

days of receipt of results. During the CAP Review, five inmate-patient medical files were reviewed for compliance. One file was found non-compliant with the requirement. The PCP reviewed, initialed, and signed the diagnostic report six days after receipt of the report. Since all five 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.

11. Question 7.4 – THE INMATE-PATIENTS DOES NOT CONSISTENTLY RECEIVE WRITTEN NOTIFICATION OF THE DIAGNOSTIC TEST RESULTS WITHIN TWO DAYS OF RECEIPT.

Prior Compliance	Current Compliance	Status
57.1%	100%	**Resolved**

During the previous audit, seven inmate-patient medical files were reviewed for compliance. Four of the seven files included documentation reflecting the inmate-patient was given written notification of the diagnostic test results within two days of facility's receipt of results, resulting in 57.1% compliance. During the CAP Review, five inmate-patient medical files were reviewed for compliance, and all were found to be compliant with this requirement. The findings show that FCRF has succeeded in addressing this deficiency in an effective manner; therefore, this item is considered resolved.

12. Question 8.4 – THE FACILITY'S NURSING STAFF DOES NOT CONSISTENTLY DOCUMENT THE REVIEW OF THE INMATE-PATIENT'S DISCHARGE PLAN UPON INMATE-PATIENT'S RETURN TO THE FACILITY FROM THE COMMUNITY HOSPITAL EMERGENCY DEPARTMENT.

Prior Compliance	Current Compliance	Status
50.0%	80.0%	**Unresolved**

During the previous audit, six inmate-patient medical files were reviewed, three included documentation reflecting the RN reviewed the discharge plan upon the inmate-patient's return from an emergency department, resulting in 50.0% compliance. During the CAP Review, five inmate-patient medical files were reviewed for compliance, one was found non-compliant with this requirement. The RN did not review the discharge plan upon the inmate-patient's return to the facility. Since all five medical records reviewed are required to be in compliance with this standard, this critical issue is considered unresolved and will be evaluated during subsequent audits until resolved.

13. Question 8.5 – THE FACILITY'S NURSING STAFF DOES NOT CONSISTENTLY DOCUMENT THE FACE-TO-FACE (FTF) EVALUATION OF INMATE-PATIENTS UPON THEIR RETURN TO THE FACILITY FROM THE COMMUNITY HOSPITAL EMERGENCY DEPARTMENT.

Prior Compliance	Current Compliance	Status
20.0%	80.0%	**Unresolved**

During the previous audit, five inmate-patient medical files were reviewed for compliance. Of the five cases reviewed, only one included documentation that the RN completed a FTF evaluation upon the inmate-patient's return to the facility from an emergency department.

During the CAP Review, five inmate-patient medical files were reviewed for compliance, one was found non-compliant with this requirement. The RN did not complete a FTF evaluation upon the inmate-patient's return to the facility. Since all five medical records reviewed are required to be in compliance with this standard, this critical issue is considered unresolved and will be evaluated during subsequent audits until resolved.

14. Question 8.7 – THE FACILITY DOES NOT HOLD MONTHLY EMERGENCY RESPONSE REVIEW COMMITTEE MEETINGS.

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

During the previous audit, it was found the facility does not hold monthly Emergency Medical Response Review Committee (EMRRC) meetings, resulting in 0.0% compliance. During the CAP Review, the audit team reviewed the EMRRC meeting minutes provided by the facility for the past five months, which reflect the facility holds EMRRC meetings monthly. The findings show that FCRF has succeeded in addressing this deficiency in an effective manner; therefore, this item is considered resolved.

15. Question 8.9 – THE FACILITY DOES NOT CONDUCT QUARTERLY EMERGENCY MEDICAL RESPONSE DRILLS ON EACH SHIFT.

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

During the previous audit, the facility was unable to provide documentation reflecting the quarterly emergency medical response drills were being conducted on each watch, resulting in 0.0% compliance. During the CAP Review, the facility provided documentation reflecting the emergency medical response drills are being conducted quarterly and on each watch. The findings show that FCRF has succeeded in addressing this deficiency in an effective manner; therefore, this item is considered resolved.

16. Question 9.3 – THE FACILITY DOES NOT HAVE A PORTABLE SUCTION DEVICE.

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

During the previous audit, the facility was missing a portable suction device, resulting in 0.0% compliance. During the CAP Review, the nurse auditor verified that the facility's portable suction device was onsite and functional during the audit. The findings show that FCRF has succeeded in addressing this deficiency in an effective manner; therefore, this item is considered resolved.

17. Question 10.1 – THE INMATE ORIENTATION MANUAL/HANDBOOK DOES NOT EXPLAIN THE HEALTH CARE GRIEVANCE/APPEAL PROCESS IN DETAIL.

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

During the previous audit, the facility's inmate orientation manual/handbook minimally addressed the health care grievance/appeal process, lacking information regarding the second and third level health care appeal processes. At that time, the audit team recommended more details and specifics regarding the health care appeal processes be added to the inmate-patient handbook. During the CAP Review, 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 addressed with the Health Services Administrator (HSA) and the Warden, who assured the audit team this deficiency will be promptly rectified. Since FCRF has failed to address this issue in an effective manner, this item is considered to be unresolved and will be evaluated during subsequent audits until resolved.

18. Question 11.2 – THE INMATE-PATIENTS WHO COME TO THE CLINIC WITH A POTENTIAL COMMUNICABLE DISEASE ARE NOT ISOLATED FROM THE REST OF THE INMATE-PATIENTS IN THE CLINIC AREA.

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

During the previous audit, the facility's clinic had only one waiting room area for inmate-patients reporting for sick call. There was no separate waiting area where an inmate-patient with a potential communicable disease may be isolated. The audit team pointed out to the medical staff that the facility has three holding cells in an area located near the clinic. The facility's staff stated that with the exception of one occasion where an inmate-patient had scabies, the cells are not utilized for isolation of inmate-patients with potential communicable diseases. If an inmate-patient has flu like symptoms, they are not isolated from the rest of the inmate-patients. During the CAP Review, the nurse auditor interviewed the HSA and learned that Receiving and Release has an isolation room where the inmate-patients with a potential communicable disease are taken, if needed to be isolated from the rest of the inmate-patients in the clinic area. During the onsite audit this requirement could not be directly observed, it was evaluated based on the nursing staff's knowledge of the process. The interviewed HSA was able to clearly identify the process and state the designated isolation cells are utilized for that specific purpose. The findings show that FCRF has succeeded in addressing this deficiency in an effective manner; therefore, this item is considered resolved.

19. Question 11.3 – THE FACILITY'S NURSING STAFF DOES NOT CONSISTENTLY PRACTICE PROPER HAND HYGIENE.

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

During the previous audit, while onsite, the nurse auditor observed facility's nursing staff not consistently practicing proper hand hygiene, resulting in 0.0% compliance. During the CAP Review, three inmate-patient encounters were observed during which the health care staff

were observed practicing proper hand hygiene. Since the findings show that FCRF has succeeded in addressing this deficiency, this item is considered resolved.

20. Question 11.6 – THE INMATE-PATIENT CLINIC AREA IS NOT BEING CLEANED AFTER EACH INMATE-PATIENT USE.

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

During the previous audit, while onsite, the nurse auditor observed the facility's health care staff not cleaning the inmate-patient clinic area after each inmate-patient use, resulting in 0.0% compliance. During the CAP Review, the facility's health care staff were observed to be cleaning the inmate-patient clinic area after each inmate-patient use. Since the findings show that FCRF has succeeded in addressing this deficiency, this item is considered resolved.

21. Question 11.10 – THE CENTRAL STORAGE AREA FOR BIOHAZARD MATERIALS IS NOT LABELED.

Prior Compliance	Current Compliance	Status
50.0%	100%	**Resolved**

During the previous audit, the central storage area for biohazard material was locked behind a chain link fence, however, the gate was not labeled, which resulted in 50.0% compliance. During the CAP Review, the auditor noted the central storage area has been moved to another location and was found locked and labeled, resulting in 100% compliance. The findings show that FCRF has succeeded in addressing this deficiency in an effective manner; therefore, this item is considered resolved.

22. Question 14.1 – THE NURSING STAFF DOES NOT CONSISTENTLY ADMINISTER MEDICATIONS TO INMATE-PATIENTS AS ORDERED BY THE PCP.

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

During the previous audit, seven inmate-patient medical files were reviewed, none included documentation that medication was administered to the inmate-patients as ordered by the PCP, resulting in 0.0% compliance. During the CAP Review, five inmate-patient medical files were reviewed for compliance and all were determined to be compliant with this requirement. Since the findings show that FCRF has succeeded in addressing this deficiency in an effective manner, this item is considered resolved.

23. Question 14.2 – THE PCP DOES NOT CONSISTENTLY DOCUMENT THAT THEY EXPLAINED THE MEDICATION TO THE INMATE-PATIENT.

Prior Compliance	Current Compliance	Status
28.6%	80.0%	**Unresolved**

During the previous audit, seven inmate-patient medical files were reviewed, two included documentation that the prescribing PCP explained the medication to the inmate-patient, resulting in 28.6% compliance. During the CAP Review, five inmate-patient medical files were reviewed for compliance, one was found non-compliant. The PCP did not document that education was provided to the inmate-patient on the newly prescribed medication. Since all five medical records reviewed are required to be in compliance with this standard, this deficiency is considered unresolved and will be evaluated during subsequent audits until resolved.

24. Question 14.4 – THE NURSING STAFF DOES NOT DOCUMENT ON THE MEDICATION ADMINISTRATION RECORD (MAR), AFTER THE MEDICATION IS ADMINISTERED TO THE INMATE-PATIENT.

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

During the previous audit, nursing staff were observed not documenting on the MAR after the Nurse Administered (NA)/Direct Observation Therapy (DOT) medication was administered to the inmate-patients, resulting in 0.0% compliance. During the CAP Review, three NA/DOT medication administration encounters were observed during the onsite visit. Nursing staff successfully documented on the MAR each dose given. Since the findings show that FCRF has succeeded in addressing this deficiency in an effective manner, this item is considered resolved.

25. Question 14.5 – THE NURSING STAFF DOES NOT CONSISTENTLY DOCUMENT ON THE MAR WHEN THE INMATE-PATIENT IS A NO SHOW FOR MEDICATION ADMINISTRATION.

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

During the previous audit, the facility was unable to provide documentation validating the nursing staff actions when an inmate-patient failed to report for medication administration, which resulted in 0.0% compliance. During the CAP Review, the medical files of three inmate-patients who had recently failed to report for their medications were reviewed, each incident was found to be documented appropriately. Since the findings show that FCRF has succeeded in addressing this deficiency in an effective manner, this item is considered resolved.

26. Question 15.1– INMATE-PATIENTS ARE NOT CONSISTENTLY SEEN WITHIN THE SPECIFIED TIME FRAMES AS SET FORTH IN THE SICK CALL POLICY.

Prior Compliance	Current Compliance	Status
96.3%	86.6%	**Resolved**

During the previous audit, it was found that of the 273 sick call appointment requests reviewed by the facility, 263 were completed by an RN within the specified time frame, resulting in 96.3% compliance. During the CAP Review, it was found that of the 723 sick call requests recorded on the sick call log, 628 inmate-patients were seen within the specified

time frame, resulting in 86.6% compliance. This represents a 9.7% decline in compliance. The facility is strongly encouraged to monitor this CAP issue closely and to address any challenges health care staff may have in completing the sick call logs accurately and timely. The findings show that FCRF has succeeded in maintaining this requirement above an acceptable standard of compliance (85.0%); therefore, this CAP item is considered resolved.

27. Question 15.2 – INMATE-PATIENTS ARE NOT CONSISTENTLY SEEN WITHIN THE SPECIFIED TIME FRAMES AS SET FORTH IN THE SPECIALTY CARE POLICY.

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

During the previous audit, the specialty care monitoring logs were found incomplete with several columns missing mandatory information/data, resulting in 0.0% compliance. During the CAP Review, the specialty care logs again were found incomplete with dates of service missing, resulting in 0.0% compliance. It should be noted that this question has been removed from the new audit instrument and will be closed out during subsequent audits. Although this specific question has been removed from the new audit instrument, the requirement to accurately record the dates of service and to submit the logs in a timely manner remains the same. Additionally this requirement will be evaluated by nursing staff in other components of the audit instrument and verification of timely inmate-patient specialty services visits will be validated and assessed during case reviews.

28. Question 15.3 – INMATE-PATIENTS ARE NOT CONSISTENTLY SEEN WITHIN THE SPECIFIED TIME FRAMES AS SET FORTH IN THE EMERGENCY/HOSPITAL SERVICES POLICY.

Prior Compliance	Current Compliance	Status
77.8%	37.5%	**Unresolved**

During the previous audit, the facility's emergency/hospital services monitoring logs indicated seven of the nine inmate-patients returning from outside emergency/hospital services were seen within the specified time frame. During the CAP Review, three out of eight inmate-patients who returned to the facility were seen within the specified time frame, resulting in 37.5% compliance. It should be noted that 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 accurately record the dates and to submit the logs in a timely manner remains the same.

29. Question 15.4 – INMATE-PATIENTS ARE NOT CONSISTENTLY SEEN WITHIN THE SPECIFIED TIME FRAMES AS SET FORTH IN THE CHRONIC CARE POLICY.

Prior Compliance	Current Compliance	Status
0.0%	61.2%	**Unresolved**

During the previous audit, the chronic care monitoring logs were found incomplete with several columns missing mandatory information/data, resulting in 0.0% compliance. During the CAP Review, the chronic care monitoring logs indicated 19 of the 49 inmate-patients

enrolled in chronic care clinic were not seen by a PCP within the specified time frame, resulting in 61.2% 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 accurately record the dates of service and to submit them in a timely manner remains the same. This requirement will be evaluated by nursing staff in other components of the audit instrument and verification of timely inmate-patient chronic care visits will be validated and assessed during case reviews.

30. Question 15.5 – INMATE-PATIENTS ARE NOT CONSISTENTLY SEEN WITHIN THE SPECIFIED TIMEFRAMES AS SET FORTH IN THE INITIAL INTAKE SCREENING POLICY.

Prior Compliance	Current Compliance	Status
84.1%	100%	**Resolved**

During the previous audit, the facility's initial intake screening monitoring logs indicated 74 of the 88 inmate-patients requiring initial health appraisal were seen by a provider within the specified time frame, resulting in 84.1% compliance. During the CAP Review, the initial intake screening monitoring logs indicated all 129 inmate-patients requiring initial health screening, were completed within the required time frame, resulting in 100% compliance. Since the findings show that FCRF has succeeded in resolving this deficiency, this CAP item is considered resolved.

31. Question 19.3 – THE INMATE-PATIENTS ARE NOT CONSISTENTLY SEEN BY THE SPECIALIST WITHIN THE TIME FRAME SPECIFIED BY THE PCP.

Prior Compliance	Current Compliance	Status
50.0%	100%	**Resolved**

During the previous audit, two inmate-patient medical files were reviewed, one indicated an audiological consultation had been ordered by the PCP; however, there was no documentation in the medical file to indicate this service had been scheduled or provided to the inmate-patient, resulting in 50.0% compliance. During the CAP Review, five inmate-patient medical files were reviewed for compliance and all were determined to be compliant with this requirement. Since the findings show that FCRF has succeeded in addressing this deficiency in an effective manner, this item is considered resolved.

32. Qualitative Action Item #1 – NOT ALL OF THE FACILITY'S CUSTODY STAFF AND VOCATIONAL INSTRUCTORS HAVE CURRENT BASIC LIFE SUPPORT (BLS) CERTIFICATIONS.

Status
Resolved

During the previous audit, the audit team found via the review of the training documentation provided by facility, not all of the facility's custody staff and vocational instructors had current BLS certifications. Custody staff are typically first responders in case of an emergency; therefore, it is essential all custody staff know how to approach and properly respond to a

medical emergency. During the CAP Review, the facility provided the audit team with a log tracking the issuance and expiration dates of custody staff BLS certifications. The audit team found that 6 of 57 current custody staff had expired BLS certifications, resulting in 89.5% compliance. Since the findings show that FCRF has succeeded in bringing this deficiency item to an acceptable standard of compliance (above 85.0%), this CAP item is considered resolved. However, the facility is strongly encouraged to ensure all of custody staff's BLS certifications are maintained current at all times and are being followed up when any staff member's BLS certification is nearing the expiration date.

33. Qualitative Action Item #2 (Chapter 5, Question 1) – THE INMATE-PATIENT'S CHRONIC CARE FOLLOW-UP VISITS ARE NOT CONSISTENTLY COMPLETED WITHIN THE 90-DAY OR LESS TIME FRAME, OR AS ORDERED BY THE TREATING PCP.

Status
Unresolved

During the previous audit, the nurse auditor reviewed seven inmate-patient medical files and found two did not include documentation that the chronic care follow-up visit was completed within the 90-day or less time frame, resulting in 83.3% compliance. During the CAP Review, five inmate-patient medical files were reviewed for compliance with this requirement. Two cases were found non-compliant as the inmate-patients were not seen within the time frame specified by the PCP, resulting in 60.0% compliance. Since all five medical records reviewed are required to be in compliance with this standard in order for the CAP item to be considered resolved, this deficiency is considered unresolved and will be evaluated during subsequent audits until resolved.

34. Qualitative Action Item #3 (Chapter 12, Question 11) – THE TREATING PCP IS NOT DOCUMENTING THE INMATE-PATIENT HEALTH APPRAISALS/HISTORY AND PHYSICAL EXAMINATIONS ON THE CDCR 196-B, *INTAKE HISTORY AND PHYSICAL* FORM.

Status
Resolved

During the previous audit, the facility was utilizing GEO forms for documenting the inmate-patient history and physical examinations, instead of the required CDCR Form 196-B, resulting in 0.0% compliance. During the CAP Review, five inmate-patient medical files were reviewed for compliance and all were found to be compliant with this requirement. Since the findings show that FCRF has succeeded in addressing this deficiency in an effective manner, this item is considered resolved.

35. Qualitative Action Item #4 (Chapter 13, Question 7) – THE FACILITY DOES NOT HAVE A SYSTEM IN PLACE TO ENSURE HEALTH CARE STAFF RECEIVES TRAINING FOR NEW OR REVISED POLICIES BASED ON *INMATE MEDICAL SERVICES POLICIES AND PROCEDURES* REQUIREMENTS.

Status
Resolved

During the previous audit, the facility did not have a system in place to ensure all health care staff receive training on new and revised/updated health care policies. During the CAP Review, the audit team was provided documentation outlining the process where the HSA tracks and records all training, which includes training on all new and revised policy items, for health care staff. The HSA maintains hard copies of all the sign-in sheets reflecting the type of training provided and completed by each staff member. Since the CAP Review process utilizes the same methodology to assess compliance as during the previous audits, the facility was determined to be in compliance with this standards and this CAP item is considered resolved. However, the audit team strongly recommends the HSA implement a tracking log listing all health care staff members and the training that was completed by each. This is to ensure none of the health care staff are ever overlooked and all receive required training on a timely basis.

36. Qualitative Action Item #5 (Chapter 17, Question 5) – THE NURSING STAFF DOES NOT CONSISTENTLY DOCUMENT THE REASON FOR THE INMATE-PATIENT'S NO-SHOW TO THEIR MEDICAL TREATMENT/APPOINTMENT.

Status
Resolved

During the previous audit, four inmate-patient medical files were reviewed, three included documentation by an RN citing the reason for the inmate-patient's failure to report to their medical appointment/treatment, resulting in 75.0% compliance. During the CAP Review, five inmate-patient medical files were reviewed for compliance and all were found to be compliant with this requirement. Since the findings show that FCRF has succeeded in addressing this deficiency in an effective manner, this item is considered resolved.

*These CAP items are 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 these CAP items 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 these CAP items 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 FCRF made considerable progress and resolved 26 out of 36 deficiencies identified in the previous audit conducted. However, the facility has 10 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. The auditors also found PCP sometimes fails to document that the inmate-patient was educated on the newly prescribed medications. Additionally, during the chart review, the auditors found the nursing staff does not consistently review the inmate-patient's discharge plan nor consistently complete FTF evaluation upon the inmate's return to the

facility from the emergency department. The effective resolution of these critical issues requires management's full commitment, follow-through and staff accountability.

At the conclusion of the onsite visit on Tuesday, November 3, 2015, the audit team met with the Warden and the HSA to discuss the findings of the CAP Review and to provide feedback and recommendations on the outstanding CAP items. Both the Warden and the HSA were receptive and open to the findings presented by the audit team. The Warden indicated that since the previous audit, the facility had a significant turnover in their health care staffing. Only two health care staff members that were originally at the facility at the time of the activation are still employed at FCRF. This may have presented the facility with some challenges in achieving and maintaining the standard and level of care required from them. The Warden also indicated that recently the GEO Group contracted with Correct Care Solutions to provide health care services at its facilities, which should help reduce the staffing turnover rate and provide some consistency in nurse staffing at the facility. FCRF has hired a full time primary care provider in September 2015; the work hours of the PCP are 0900 to 1700 hours, Monday through Friday. Currently, there was no backlog of PCP appointments identified during the onsite review.

It is evident that FCRF 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 within the management's scope of control to ensure compliance. The Warden must make the resolution of these critical items a priority, holding the managers and supervisors responsible for managing the health care functions within this facility. The facility Warden voiced her desire to provide quality and timely health care services to the inmate-patients housed at FCRF and assured the audit team the outstanding 10 CAP items will be addressed and resolved as soon as possible.