November 13, 2015

Eldridge Pressley, Warden
Golden State Modified Community Correctional Facility
611 Frontage Road
McFarland, CA, 93250

Dear Warden Pressley,

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 Golden State Modified Community Correctional Facility (GSMCCF) on November 3, 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 during the previous health care audit conducted at your facility on May 20 through 22, 2015.

Attached you will find a CAP Review report which lists all items that were identified deficient during the previous audit along with a brief narrative describing the facility's progress towards the resolution of each deficiency. Be advised each unresolved CAP item will require your facility to take necessary action to expediently resolve the deficiency as it will be re-examined during the subsequent audit.

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 (HPM 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
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Steven Moulios, D.O., Physician Advisor, Central Region, Utilization Management, CCHCS
Joseph Williams, Correctional Administrator, Field Operations, Corrections Services, CCHCS
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Luzviminda Pareja, NCPR, Field Operations, Corrections Services, CCHCS
Patricia Matranga, R.N., Nursing Services, CCHCS
Donna Heisser, HPM II, PPCMU, Field Operations, Corrections Services, CCHCS

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

CONTRACT FACILITY HEALTH CARE MONITORING AUDIT

Corrective Action Plan Review

Golden State Modified Community Correctional Facility

November 3, 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 3, 2015 at Golden State Modified Community Correctional Facility (GSMCCF), which is located in McFarland, California. At the time of the audit, CDCR's *Weekly Population Count*, dated October 30, 2015, indicated that GSMCCF had a design capacity of 700 beds, of which 672 were occupied with CDCR inmates.

EXECUTIVE SUMMARY

On November 3, 2015, the CCHCS audit team conducted a CAP review at GSMCCF. The audit team consisted of the following personnel:

P. Matranga, Registered Nurse
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 audit was scheduled to be conducted at GSMCCF. 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 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 audit conducted at GSMCCF on May 20 through 22, 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: Most of the administrative items that were previously identified to be deficient are related to the facility's lack of policies and procedures, absence of training logs, absence of a mechanism to track release of information, health care appeals, licenses and certifications, contracts etc. The facilities are requested to submit the pertinent documentation to Private Prison Compliance and Monitoring Unit (PPCMU) before the onsite CAP Reviews. The auditors review the documents received from the MCCF and determine compliance.

iii. Onsite observation and interviews with MCCF staff: Some of CAP items previously identified are as a result of onsite inspections and observations of facility's various medical processes and staff interviews during the previous audit. The auditors review these issues during the onsite CAP review. The nurse and HPS I auditors conduct inspections of various clinical and housing areas of the facility, interview key facility personnel which also include medical staff for the overall purpose of evaluating compliance of the identified issues and also 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 audit and the total number of CAP items that were found to be resolved and unresolved during the CAP Review process.

Table 1.1

GSMCCF CAP Review – November 4, 2015			
Chapter	**Total Number of CAP Items Identified**	**Number of Resolved Items**	**Number of Unresolved Items**
1. Administration	1	1	0
2. Access to Health Care Information	1	1	0
3. Chronic Care	1	1	0
4. Medical Emergency Services/Drills	3	3	0
5. Medical Emergency Equipment	1	1	0
6. Grievance/Appeal Procedure	1	1	0
7. Initial Intake Screening/Health Appraisal	2	2	0
8. Medication Management	1	1	0
9. Monitoring Logs	1	0	1
10. Sick Call	2	2	0
Overall	**14**	**13**	**1**

The CAP items found unresolved during this CAP review process will remain active. 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. For unresolved CAP items identified at the conclusion of the CAP review, the facility will submit a revised CAP to the Chief of the Contract Beds Unit within the Division of Adult Institutions outlining details for resolution.

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

LIST OF NEW ISSUES IDENTIFIED DURING THE CAP REVIEW

Table 1.2

Operational Area	Identified Issues
N/A	There were no new issues identified during the CAP Review process.

IDENTIFIED AND OUTSTANDING CAP ITEMS – GSMCCF

Table 1.3

Chapter/Question	Outstanding CAP item
Chapter 15, Question 4	The documentation in the facility's chronic care log showed that inmate-patients scheduled for chronic care appointments are not consistently seen within the specified time frames.

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 section of this report.

CAP ITEM REVIEW

The Contract Facility Health Care Monitoring Audit, conducted at GSMCCF on May 20-22, 2015, resulted in the identification of 14 quantitative CAP items. During the CAP Review, the audit team found 13 of the 14 items resolved, with the remaining 1 not resolved within acceptable standards. Below is a discussion of each CAP item.

1. Question 1.5 – THE FACILITY'S WRITTEN POLICY DOES NOT ADDRESS ALL THE DOCUMENTATION REQUIREMENTS FOR RELEASE OF INFORMATION.

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

This issue was initially identified during the November 2014 audit and was found unresolved during the audit conducted in May 2015. During the CAP Review, GSMCCF was found compliant with this requirement as the facility had revised their local operating procedure (LOP) to address the requirement of documenting all written requests on the Release of Information (ROI) log. Since the findings show that GSMCCF has succeeded in addressing this deficiency in an effective manner, this CAP item is considered closed.

2. Question 2.4 – THE FACILITY'S RELEASE OF INFORMATION LOG DOES NOT CONTAIN ALL THE REQUIRED INFORMATION.

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

During the previous audit, the facility was found missing several required data fields on the ROI log such as: the number of pages copied, amount the inmate-patient was charged for the copies, the date of the completion of the request, and the name/signature of the staff completing the request. During the CAP Review, the facility's ROI log was found containing all the required data fields. Since the findings show that GSMCCF has succeeded in addressing this deficiency in an effective manner, this CAP item is considered closed.

3. Question 5.1 - THE INMATE-PATIENTS ARE NOT CONSISTENTLY SEEN FOR THEIR CHRONIC CARE APPOINTMENTS WITHIN THE 90 DAY OR LESS TIME FRAME OR AS ORDERED BY THE PRIMARY CARE PROVIDER.

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

During the previous audit, of the six inmate-patient medical files reviewed, one 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, and all were seen for their chronic care appointment within the required time frame. Since the findings show that GSMCCF has succeeded in addressing this deficiency, this CAP item is considered closed.

4. Question 8.5 – THE FACILITY NURSING STAFF DOES NOT CONSISTENTLY DOCUMENT THE COMPLETION OF A FACE-TO-FACE EVALUATION OF THE INMATE-PATIENTS UPON THEIR RETURN FROM THE COMMUNITY HOSPITAL EMERGENCY DEPARTMENT.

Prior Compliance	Current Compliance	Status
66.7%	100%	**Resolved**

During the previous audit, of the three inmate-patient medical files reviewed, one did not include documentation that the nursing staff completed a face-to-face (FTF) evaluation of the inmate-patient upon his return to the facility from a community hospital emergency department. During the CAP Review, only one inmate-patient was identified to have returned to the MCCF after a visit to the community hospital emergency department for the audit review period of February through September 2015. The review of this inmate-patient's medical file showed that the nursing staff completed a FTF evaluation upon the inmate's return to the facility. Since the findings show that GSMCCF has succeeded in addressing this deficiency, this CAP item is considered closed.

5. Question 8.6 – THE INMATE-PATIENTS DO NOT CONSISTENTLY RECEIVE A FOLLOW-UP APPOINTMENT WITH THE PRIMARY CARE PROVIDER UPON THEIR RETURN FROM THE COMMUNITY HOSPITAL EMERGENCY DEPARTMENT.

Prior Compliance	Current Compliance	Status
66.7%	100%	**Resolved**

During the previous audit, of the three inmate-patient medical files reviewed, one did not include documentation that the inmate-patient was seen by a primary care provider (PCP) upon his return to the facility from a community hospital emergency department. During the CAP Review, only one inmate-patient was identified to have returned to the MCCF after a visit to the community hospital emergency department for the audit review period of February through September 2015. The review of this inmate-patient's medical file showed that the inmate-patient was seen by a PCP for a follow-up upon his return to the facility from an emergency department. Since the findings show that GSMCCF has succeeded in addressing this deficiency, this CAP item is considered closed.

6. Question 8.9 – THE FACILITY DOES NOT CONDUCT QUARTERLY EMERGENCY MEDICAL RESPONSE (MAN-DOWN) DRILLS.

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

During the previous audit, the review of the Emergency Medical Response Review Committee meeting minutes showed that the facility only conducted monthly fire drills and did not conduct medical emergency response (man-down) drills quarterly. During the CAP Review, the facility provided the audit team with documentation reflecting the medical emergency response drills were being conducted quarterly on each watch. Since the findings show that GSMCCF has succeeded in addressing this deficiency in an effective manner, this CAP item is considered closed.

7. Question 9.10 – NOT ALL OF THE FACILITY'S FIRST-AID KITS CONTAIN ALL THE REQUIRED ITEMS.

Prior Compliance	Current Compliance	Status
71.4%	92.9%	**Resolved**

During the previous audit, of the seven first-aid kits inspected, two were found missing the cardiopulmonary resuscitation masks, resulting in 71.4% compliance. During the CAP Review, of the 14 first aid-kits inspected, one was found missing the required items, resulting in 92.9% compliance. Since the findings show that GSMCCF has succeeded in bringing this deficiency to an acceptable standard of compliance (above 85.0%), this CAP item is considered closed.

8. Question 10.1 – THE FACILITY'S INMATE-PATIENT ORIENTATION HANDBOOK/MANUAL DOES NOT ADDRESS THE HEALTH CARE GRIEVANCE/APPEAL (602 HC) PROCESS IN DETAIL.

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

During the previous audit, review of the GSMCCF's *Inmate Orientation Handbook* revealed the handbook did not clearly explain or define the second and third level health care appeal processes, nor did it mention where the completed CDCR Forms 602-HC were to be submitted, resulting in 0.0% compliance. During the CAP Review, the auditor reviewed GSMCCF's revised *Inmate Orientation Handbook* and determined it explained the health care grievance/appeal process in substantial detail. Since the findings show that GSMCCF has succeeded in addressing this deficiency in an effective manner, this CAP item is considered closed.

9. Question 12.8 – THE FACILITY'S NURSING STAFF DO NOT CONSISTENTLY IDENTIFY THE INMATE-PATIENTS' CURRENT PRESCRIPTION MEDICATION ORDERS WITHIN 24 HOURS OF THEIR ARRIVAL AT THE FACILITY.

Prior Compliance	Current Compliance	Status
80.0%	100%	**Resolved**

During the previous audit, of the five inmate-patient medical files reviewed, one inmate-patient's medical file reflected the medication was not re-ordered by the RN within 24 hours of the inmate-patient's arrival at the facility, resulting in 80.0% compliance. During the CAP Review, five inmate-patient medical files were reviewed for this standard and all were determined to be in compliance with this requirement. Since the findings show that GSMCCF has succeeded in addressing this deficiency, this CAP item is considered closed.

10. Question 12.12 – THE INMATE-PATIENTS ARE NOT CONSISTENTLY RECEIVING ORIENTATION REGARDING THE PROCEDURES FOR ACCESSING HEALTH CARE AT THE TIME OF INITIAL INTAKE SCREENING.

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

During the previous audit, of the eight inmate-patient medical files reviewed, four medical files did not include documentation that the inmate-patients receive orientation on the facility's procedures for accessing health care, resulting in 50.0% compliance. During the CAP Review, five inmate-patient medical files were reviewed and all were found to be in compliance with this requirement. Since the findings show that GSMCCF has succeeded in addressing this deficiency, this CAP item is considered closed.

11. Question 14.10 – THE INMATE-PATIENTS DO NOT TAKE THEIR KEEP-ON-PERSON MEDICATIONS TO THE NURSING STAFF PRIOR TO THEIR TRANSFER FROM THE FACILITY.

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

During the previous audit, as there were no inmate-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 stated that inmate-patients did not bring their keep-on-person medications to the nursing staff prior to transfer, which resulted in 0.0% compliance. During the CAP Review, the nurse auditor reviewed the transfer form from a transfer that occurred earlier on the day of the onsite review and found that medication is being verified by nursing staff prior to the inmate-patient's transfer from the facility and that nursing staff are knowledgeable on this process. Since the findings show that GSMCCF has succeeded in addressing this deficiency, this CAP item is considered closed.

12. Question 15.4 – THE DOCUMENTATION IN THE FACILITY'S CHRONIC CARE LOG SHOWED THAT INMATE-PATIENTS SCHEDULED FOR CHRONIC CARE APPOINTMENTS ARE NOT CONSISTENTLY SEEN WITHIN THE SPECIFIED TIME FRAMES.

Prior Compliance	Current Compliance	Status
44.3%	32.8%	**Unresolved**

During the previous audit, review of the facility's chronic care monitoring logs indicated that 34 of the 61 inmate-patients referred to chronic care clinic were not seen by a PCP within the specified time frame, resulting in 44.3% compliance. During the CAP Review, review of the chronic care monitoring logs indicated that 41 of the 61 inmate-patients enrolled in chronic care clinic were not seen by a PCP within the specified time frame, resulting in 32.8% 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. However, it bears mentioning that, although this specific question has been removed from the new audit instrument, the requirement to maintain the chronic care log, to accurately record the dates of service on these logs and to submit the logs timely, remains the same.

13. Question 18.1 – THE FACILITY'S INMATE-PATIENT ORIENTATION HANDBOOK/MANUAL DOES NOT PROVIDE ALL DETAILS ON THE SICK CALL (CDCR 7362) PROCESS.

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

During the previous audit, review of the GSMCCF's *Inmate Orientation Handbook* revealed the handbook did not clearly explain or define the sick call (CDCR Form 7362) process, resulting in 0.0% compliance. During the CAP Review, the auditor reviewed the GSMCCCF's revised *Inmate Orientation Handbook* and determined it adequately explains the sick call process. Since the findings show that GSMCCF has succeeded in addressing this deficiency in an effective manner, this CAP item is considered closed.

14. Question 18.6 – THE FACILITY'S NURSING STAFF ARE NOT CONSISTENTLY COMPLETING THE S.O.A.P.E (SUBJECTIVE, OBJECTIVE, ASSESSMENT, PLAN, EDUCATION) NOTES ON THE CDCR FORM 7362, *HEALTH CARE SERVICES REQUEST* AND/OR CDCR 7230, *INTERDISCIPLINARY PROGRESS NOTES*, OR A SIMILAR MCCF FORM.

Prior Compliance	Current Compliance	Status
77.8%	100%	**Resolved**

During the previous audit, of the nine inmate-patient medical files reviewed, two cases reflected that nursing staff were not documenting in the inmate-patient's chart utilizing the SOAPE format, resulting in 77.8% compliance. During the CAP Review, five inmate-patient medical files were reviewed and all were found in compliance with this requirement. Since the findings show that GSMCCF has succeeded in addressing this deficiency in an effective manner, this CAP item is considered closed.

CONCLUSION

Golden State Modified Community Correctional Facility resolved all, but one, of the identified deficiencies from the previous audit conducted at the facility in May 2015. The one outstanding CAP item, relative to the chronic care monitoring log, will be closed out during the subsequent audit as a result of the change to methodology in the new audit instruction guide, which was provided to all contract facilities on October 5, 2015. The facility's Health Services Administrator stated that initially there was some confusion and misunderstanding regarding how to correctly complete the chronic care monitoring log, but with the help of PPCMU staff, she was able to resolve the issues. Nevertheless, it is evident that GSMCCF has demonstrated the ability to make improvements based on the numerous resolved items and should be commended for the effort all staff have taken to improve and resolve the deficiencies identified during the previous audit.