December 3, 2015

Tammy Holt, Captain
Taft Modified Community Correctional Facility
330 Commerce Way
Taft, CA, 93268

Dear Captain Holt,

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 Taft Modified Community Correctional Facility (TMCCF) 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 at the time of the previous health care audit conducted at your facility on April 7 through 8, 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 TMCCF was able to effectively resolve 15 of 19 CAP items, with 4 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 TMCCF 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
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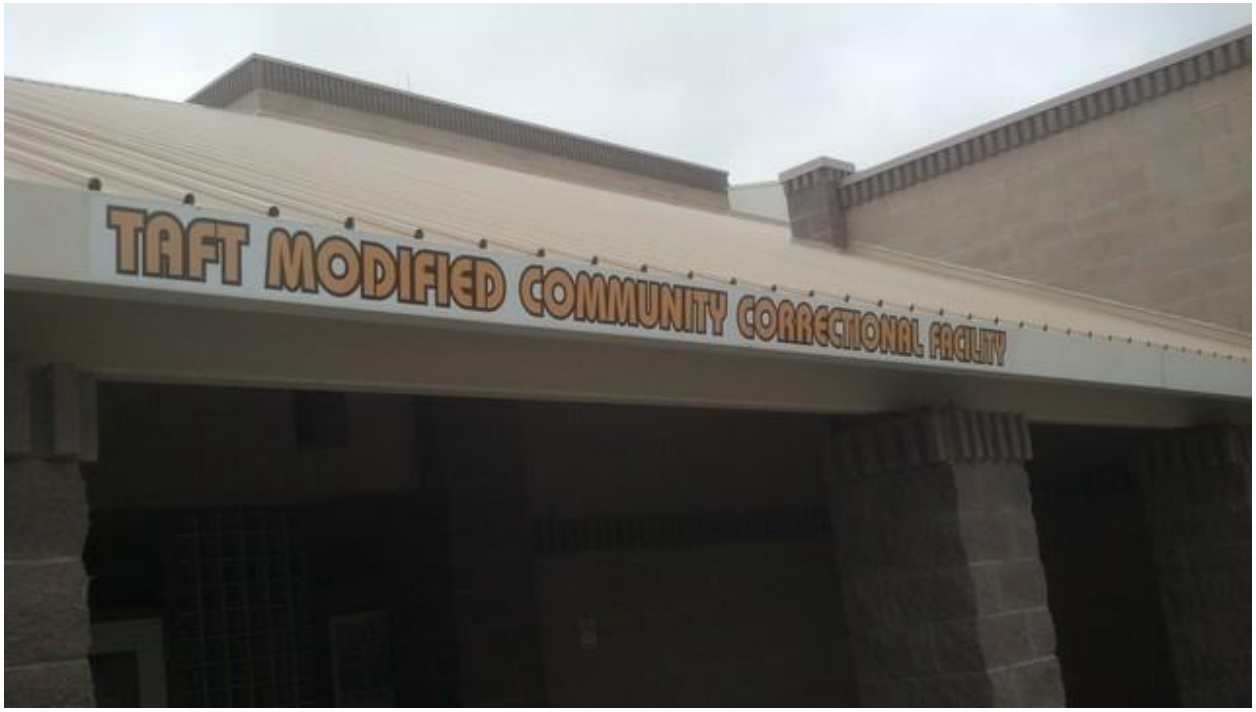
Michael J. Williams, Chief Deputy Administrator, Contract Beds Unit, COCF, DAI, CDCR
Steven Moulios, D.O., Physician Advisor, Central Region, Utilization Management, CCHCS
Joseph Williams, Correctional Administrator, Field Operations, Corrections Services, CCHCS
Linda Wong, Manager, Office of Audits and Court Compliance, CDCR
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



Taft 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 Taft Modified Community Correctional Facility (TMCCF), which is located in Taft, California. At the time of the audit, CDCR's *Weekly Population Count* report, dated October 30, 2015, indicated that TMCCF had a design capacity of 600 beds, of which 572 were occupied with CDCR inmates.

EXECUTIVE SUMMARY

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

L. Pareja, Nurse Consultant Program Review
D. Heisser, Health Program Manager II
C. Troughton, 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 TMCCF. 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 TMCCF on April 7 through 8, 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 Record (eUHR) 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 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

TMCCF CAP Review – November 3, 2015			
Chapter	**Total Number of CAP Items Identified**	**Number of Resolved Items**	**Number of Unresolved Items**
1. ADA Compliance	6	6	0
2. Diagnostic Services	1	1	0
3. Medical Emergency Services/Drills	2	2	0
4. Medical Emergency Equipment	2	2	0
5. Infection Control	1	1	0
6. Initial Intake Screening/Health Appraisal	1	1	0
7. Monitoring Logs	2	0	2
8. Sick Call	2	1	1
9. Specialty/Hospital Services	2	1	1
Overall	**19**	**15**	**4**

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)
Qualitative Action Item #1 Infection Control	The nursing staff was observed not using proper hand hygiene after each inmate-patient encounter.
Qualitative Action Item #2 Medication Management	The nursing staff was observed not checking the inmate-patient's mouth, hands, and cup after administering the Direct Observation Therapy (DOT) medication(s).

IDENTIFIED AND OUTSTANDING CRITICAL ISSUES – TMCCF

Table 1.3

Chapter/Question	Unresolved Critical Issues
Chapter 15, Question 3	The facility's emergency/hospital services monitoring log lacks documentation that inmate-patients are consistently seen within the specified time frames as set forth in the emergency/hospital services policy.
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.
Chapter 18, Question 6	The nursing staff is not consistently documenting the face-to-face sick call encounter with an inmate-patient in Subjective, Objective, Assessment, Plan, and Education (SOAPE) format.
Chapter 19, Question 5	The nursing staff is not consistently notifying the primary care provider of any medication orders or follow-up instructions from the specialty consultant, upon the inmate-patient's return from a specialty care appointment.

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 TMCCF on April 7-8, 2015, resulted in the identification of 19 quantitative CAP items. During the CAP Review, auditors found 15 of the 19 items resolved, with the remaining 4 unresolved within acceptable standards. Below is a discussion of each CAP item.

1. Question 3.1 – THE FACILITY DOES NOT HAVE A LOCAL OPERATING PROCEDURE TO TRACK AND MONITOR DISABILITY PLACEMENT PROGRAM (DPP) INMATE-PATIENTS AND THEIR ACCOMMODATION(S).

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

During the previous audit, the facility did not have a Local Operating Procedure (LOP) that addressed the procedure to track and monitor DPP inmate-patients and their accommodations, resulting in 0.0% compliance. During the CAP Review, the facility provided the audit team with the LOP, clearly outlining how the facility will track and monitor DPP inmate-patients and their accommodations. The findings show that TMCCF has successfully addressed this deficiency, this item is considered resolved.

2. Question 3.2 – THE FACILITY DOES NOT HAVE A LOCAL OPERATING PROCEDUE TO TRACK THE PROVISION OF HEALTH CARE APPLIANCES FOR ALL DPP INMATE-PATIENTS.

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

The findings of the April 2015 audit reflect the facility did not have a LOP that addressed the procedure to track the provision of health care appliances for all DPP inmate-patients, resulting in 0.0% compliance. As part of the documentation production process for the current audit, the facility provided the audit team with the LOP clearly outlining how the facility is going to track the provisions of health care appliances given to all DPP inmate-patients. The findings show that TMCCF successfully addressed this deficiency, this item is considered resolved.

3. Question 3.3 – THE FACILITY DOES NOT HAVE A LOCAL OPERATING PROCEDURE TO TRACK THE REPAIR OF HEALTH CARE APPLIANCES FOR ALL DPP INMATE-PATIENTS.

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

Previous audit findings reflect the facility did not have an LOP that addressed the procedure to track the repair of health care appliances for all DPP inmate-patients, resulting in 0.0% compliance. During the current review, the facility provided the audit team with the LOP clearly outlining how the facility is going to track the repair of health care appliances for all DPP inmate-patients. The findings show that TMCCF successfully addressed this deficiency, this item is considered resolved.

4. Question 3.4 – THE FACILITY DOES NOT HAVE A LOCAL OPERATING PROCEDURE THAT EXPLAINS PROVISION OF INTERIM ACCOMMODATION TO A DPP INMATE-PATIENT WHILE AN APPLIANCE IS ORDERED, REPAIRED, OR IS 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 outlining the process for the provision of interim accommodation. The findings show that TMCCF successfully addressed this deficiency, this item is considered resolved.

5. Question 3.5 –THE FACILITY DOES NOT HAVE A LOCAL OPERATING PROCEDURE THAT DEFINES A PROCESS TO ADD OR REMOVE AN INMATE-PATIENT FROM THE DPP LIST.

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

The facility's DPP LOP, submitted during the previous audit, 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 current review, the facility provided the audit team with an LOP clearly explaining and outlining the process. The findings show that TMCCF successfully addressed this deficiency, this item is considered resolved.

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

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

The findings of the previous audit show 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. As part of the documentation production process for the current audit, the facility provided the audit team with an LOP explaining and defining the process. The findings show that TMCCF has successfully addressed this deficiency, this item is considered resolved.

7. Question 7.2 –THE PRIMARY CARE PROVIDER (PCP) DOES NOT CONSISTENTLY REVIEW, INITIAL, AND DATE INMATE-PATIENTS' DIAGNOSTICE TESTS WITHIN THE SPECIFIED TIME FRAME.

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

During the April 2015 audit, five inmate-patient medical files were reviewed for compliance. Of the five files reviewed, four included documentation the PCP had reviewed, initialed, and dated the inmate-patient's diagnostic report within two days of receipt. During the current eUHR review, five inmate-patient medical files were reviewed for compliance and all were found to be compliant with this requirement. The findings show that TMCCF has successfully addressed this deficiency, this item is considered resolved.

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

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

The April 2015 audit findings reflected the facility's Emergency Response Review Committee (EMRRC) meeting minutes did not include documentation on the response times of the BLS certified staff members during the emergency medical response and/or drills. As part of the documentation production process for the current audit, the facility provided the audit team with documentation addressing the four emergency response/drills, all of which documented the response times of the BLS certified staff. The findings show that TMCCF has successfully addressed this deficiency, this item is considered resolved.

9. Question 8.11 –THE FACILITY DOES NOT DOCUMENT THE RESPONSE TIMES OF ADVANCED CARDIAC LIFE SUPPORT (ACLS) CERTIFIED MEDICAL STAFF DURING EMERGENCY MEDICAL RESPONSE AND/OR DRILLS.

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

The findings of the previous audit reflected the facility's EMRRC meeting minutes did not include documentation on the response times of the ACLS certified staff members during the emergency medical response and/or drills. As part of the documentation production process for the current audit, the facility provided the audit team with documentation addressing four emergency response/drills. All documented the response times of the ACLS certified staff. The findings show that TMCCF has successfully addressed this deficiency, this item is considered resolved.

10. Question 9.6 –THE REGISTERED NURSES ARE NOT CONSISTENTLY VERIFYING OXYGEN TANKS ARE THREE-FOURTHS FULL WHEN CONDUCTING OPERATIONAL READINESS CHECKS ON EACH SHIFT.

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

This issue was initially identified during the September 2014 audit. During the April 2015 onsite visit, the auditors verified that the two oxygen tanks were checked on every shift for operational readiness. Although both tanks were checked daily, one of the tanks was half full and did not

meet the required level for operational readiness. While conducting the current onsite CAP Review, the auditors verified that both oxygen tanks were checked and at the required levels for operational readiness. The findings show that TMCCF has successfully addressed this deficiency, this item is considered resolved.

11. Question 9.11 –THE FACILITY DOES NOT HAVE SPILL KITS IN ANY OF THE DESIGNATED AREAS.

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

The facility did not have spill kits in any of the designated areas at the facility during the April 2015 audit. During the current onsite visit, auditors verified that all 11 spill kits were in all required locations at the facility. The findings show that TMCCF has successfully addressed this deficiency, this item is considered resolved.

12. Question 11.12 –THE RN'S ARE NOT CONSISTENTLY ACCOUNTING FOR ALL SHARPS AT THE END OF EACH SHIFT.

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

During the April 2015 onsite visit, the facility was found not documenting that all sharps are checked on each shift, resulting in 0.0% compliance. While conducting the onsite CAP Review, auditors confirmed that the facility was documenting all sharps are accounted for at the end of each shift. The findings show that TMCCF has successfully addressed this deficiency, this item is considered resolved.

13. Question 12.12 –DURING THE INITIAL INTAKE SCREENING PROCESS, THE INMATE-PATIENTS DO NOT RECEIVE ORIENTATION REGARDING THE PROCEDURES FOR ACCESSING HEALTH CARE.

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

The previous audit findings showed that of the four inmate-patient medical files reviewed, not one included documentation reflecting the inmate-patients had received orientation regarding the facility's procedures for accessing health care. During the current review, five inmate-patient medical files were reviewed and all contained documentation fulfilling this requirement. The findings show that TMCCF has successfully addressed this deficiency, this item is considered resolved.

14. Question 15.3 –THE FACILITY'S EMERGENCY/HOSPITAL SERVICES MONITORING LOGS LACK DOCUMENTATION THAT INMATE-PATIENTS ARE CONSISTENTLY SEEN WITHIN THE SPECIFIED TIME FRAMES AS SET FORTH IN THE EMERGENCY/HOSPITAL SERVICES POLICY.

Prior Compliance	Current Compliance	Status
75.0%	66.7%	**Unresolved**

The emergency/hospital services monitoring logs, reviewed during the April 2015 audit, documented a total of six inmate-patients were transported offsite for emergency services. Post hospital discharge, two inmate-patients remained at the Hub institution, the remaining four were returned to TMCCF from the emergency department. Of the four inmate-patients that returned, three were seen within the specified time frame, resulting in 75.0% compliance. The monitoring logs, reviewed during the current audit, reflected two of the three inmate-patients that were sent to the emergency room and returned to the facility were seen by the PCP within the specified time frame, resulting in 66.7% 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 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-patients emergency services follow-up visits will be validated and assessed during future case reviews.

15. 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
75.3%	62.5%	**Unresolved**

During the previous audit, the chronic care monitoring logs documented a total of 81 inmate-patients were referred to the chronic care clinic. Of the 81 inmate-patients referred, 61 were seen by the PCP within the specified time frame, resulting in 75.3% compliance. During the pre-audit documentation review process, the chronic care monitoring logs indicated that 55 of the 88 inmate-patients that were scheduled to see a provider for their chronic care appointment were seen on time, resulting in 62.5% compliance. This represents a 12.8% decline in compliance. The facility is strongly encouraged to monitor this critical issue closely and to address any challenges health care staff may have in completing the chronic care logs accurately and timely. 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 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-patients chronic care visits will be validated and assessed during future case reviews.

16. Question 18.2 –THE RNS ARE NOT CONSISTENTLY REVIEWING SICK CALL REQUEST FORMS (CDCR FORMS 7362) WITHIN ONE BUSINESS DAY OF RECEIPT.

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

The April 2015 audit findings showed that the RNs are not consistently reviewing the sick call request forms within one business day of receipt. Of the 12 inmate-patient medical files reviewed, 10 included documentation that the RN reviewed the sick call slips within one day of

receipt, resulting in 83.3% compliance. Five inmate-patient medical files were reviewed during the current audit and all were found compliant with this requirement. The findings show that TMCCF has successfully addressed this deficiency, this item is considered resolved.

17. Question 18.6 –THE RNS ARE NOT COMPLETING THE S.O.A.P.E NOTES ON THE CDCR FORM 7362 *HEALTH CARE SERVICE REQUEST* AND/OR CDCR 7230, *INTERDISCIPLINARY PROGRESS NOTES,* OR A SIMILAR MCCF FORM.

Prior Compliance	Current Compliance	Status
0.0%	80.0%	**Unresolved**

This issue was initially identified during the September 2014 audit. Of the 12 inmate-patient medical files reviewed during the April 2015 audit, not one included a fully completed S.O.A.P.E note. During the current review, five inmate-patient medical files were reviewed and one was found non-compliant with this requirement. The non-compliant record was a result of poor documentation of the inmate-patient's respiratory problems. The only objective documented was the inmate-patient's vital signs. 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.

18. Question 19.4 – THE RNS ARE NOT CONSISTENTLY COMPLETING FACE-TO-FACE (FTF) EVALUATION UPON INMATE-PATIENT'S RETURN FROM A SPECIALTY CARE APPOINTMENT.

Prior Compliance	Current Compliance	Status
75.0%	100%	**Resolved**

During the April 2015 audit, four inmate-patient medical files were reviewed. Three of the files indicated inmate-patients received a FTF evaluation with an RN upon the inmate-patient's return from a specialty consultation appointment, resulting in 75.0% compliance. During the CAP Review, five inmate-patient medical files were reviewed and all were found to be compliant with this requirement. The findings show that TMCCF has successfully addressed this deficiency, this item is considered resolved.

19. Question 19.5 –THE RNS ARE NOT CONSISTENTLY NOTIFYING THE PCP OF ANY IMMEDIATE MEDICATION ORDERS OR FOLLOW-UP INSTRUCTIONS FROM THE SPECIALTY CONSULTANT, UPON THE INMATE-PATIENTS' RETURN FROM A SPECIALTY CARE APPOINTMENTS.

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

This issue was initially identified during the September 2014 audit. Of the four inmate-patient medical files reviewed during the previous audit, two reflected inmate-patients had follow-up instructions. The RN notified the PCP of only one inmate-patient's follow-up instructions, resulting in 50.0% compliance. During the current audit, five inmate-patient medical files were reviewed and all included documentation that the RN reviewed the discharge instructions; however, the RN did not sign and date one of the forms, making that form non-compliant. Without the RN's signature and date, the service is viewed as though it did not occur. TMCCF

has failed to address this issue in an effective manner; therefore, this item is considered unresolved and will be evaluated and monitored during subsequent audits.

CONCLUSION

During the CAP Review process, the audit team found that TMCCF has made a significant improvement in resolving 15 out of 19 deficiencies identified in the previous audit. Although the facility has made great strides to resolve all CAP items, four unresolved CAP items still remain. It is critical that the management and supervisors of this facility step up and hold their staff accountable to fix the remaining critical issues that are unresolved. Most of the issues are minor in nature and should be easily rectified. During the chart review the auditors found that the nursing staff failed to consistently document the FTF sick call encounters in the S.O.A.P.E. format. Additionally, in one of the cases reviewed, auditors found that an RN had thoroughly documented an inmate-patient's FTF evaluation from a specialty appointment; however, the RN failed to sign and date the progress notes, resulting in negative outcome. 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.

While onsite, the auditors had a discussion with health care staff on the requirements and expectations for filling out all monitoring logs appropriately. On September 9, 2015, PPCMU emailed all MCCFs the revised monitoring logs along with an Instruction guide; the Administrative Assistant and the Health Services Administrator (has) acknowledged receiving this email. The auditors reiterated to the health care staff that although the monitoring logs had slight changes and will be audited in a slightly differently manner in the future; however, the timely submission of all monitoring logs has not changed. It should be noted that the monitoring logs received after September 9, 2015, have been completed correctly and all data fields are filled in appropriately.

While the facility is working to address the four outstanding CAP items from the previous audit, two additional CAP items were identified during this CAP Review. During the onsite visit, the auditors observed one of the nursing staff conducting inmate-patient sick call appointments and administration of DOT medications. During the sick call appointment, the nurse was observed not washing her hands in between clinical encounters, then proceeded to perform various other nursing functions before washing her hands. During the DOT medication administration, the same nurse was observed not consistently checking the mouth, cup and hands of the inmate-patients. On one instance, the custody officer required the inmate-patient to open his mouth and hands before he left the clinic. This information was provided to the HSA and the facility staff, who expressed appreciation for the reminder. These two new critical issues were shared with the Warden during the exit conference; where he was further advised that the issues will be evaluated and re-examined during subsequent audits until resolved.

TMCCF should be commended on their willingness to be proactive in closing the majority of their CAP items. Since the October 1, 2015 executive meeting, the HSA has devised an internal audit system based on the *Private Prison Compliance and Health Care Monitoring Audit Instruction Guide* for all nursing staff members to conduct weekly self audits. During the exit meeting with the Facility Captain and the HSA, they reiterated their dedication to close all the remaining and newly identified CAP items.