February 5, 2019

Gerard Brochu, Warden
Patsy Brinson, Health Services Administrator
Golden State Modified Community Correctional Facility
611 Frontage Road
McFarland, CA 93250

Dear Warden Brochu and Ms. Brinson,

The staff from California Correctional Health Care Services (CCHCS) completed an onsite Private Prison Compliance and Health Care Monitoring Limited Review audit at Golden State Modified Community Correctional Facility (DVMCCF) on December 4 and 5, 2018. The purpose of this audit was to examine the facility's progress in resolving inadequate components and critical issues identified during the May 2018 annual audit.

On January 25, 2018, a draft report was provided to allow you the opportunity to review and dispute any findings presented in the report. On January 29, 2018, you submitted a response accepting the findings.

Attached is the final limited review audit report. The scope of the limited review included a re-examination of six components, and 23 critical issues. As a result of the audit, the rating for only one component increased, Component 7, Initial Health Assessment/Health Care Transfer. The facility continues to struggle with achieving compliance in the other five components; Administrative Operations, Internal Monitoring and Quality Management, Access to Care, Emergency Services and Community Hospital Discharge, Initial health Assessment/Health Care Transfer, and Emergency Medical Response/Drills and Equipment. Of the 23 critical issues, 13 were found resolved, and 13 new critical issues were identified.

Thank you for your assistance and please extend my gratitude to your staff for their professionalism and cooperation during this audit. Should you have any questions or concerns, you may contact Anastasia Bartle, Program Manager, Private Prison Compliance and Monitoring Unit, Field Operations, Corrections Services, CCHCS, at (916) 691-4921 or via email at Anastasia.Bartle@cdcr.ca.gov.

Sincerely,

Joseph (Jason) Williams, Deputy Director
Field Operations, Corrections Services
California Correctional Health Care Services

Enclosure

cc: Jeff Macomber, Director, Corrections Services, CCHCS
Joseph W. Moss, Chief, Contract Beds Unit (CBU), Division of Adult Institutions (DAI), California Department of Corrections and Rehabilitation (CDCR)
Edward Vasconcellos, Chief Deputy Warden, CBU, DAI, CDCR
Brian Coates, Associate Warden, CBU, DAI, CDCR
Jay Powell, Correctional Administrator, Health Care Placement Oversight Program (HCPOP) and PPCMU, Field Operations, Corrections Services, CCHCS
Joseph K. Edwards, Captain, HCPOP and PPCMU, Field Operations, Corrections Services, CCHCS
Ted Kubicki, Chief Executive Officer, North Kern State Prison, CCHCS
Tiffany Thompson, RN, Western Region Operations Manager, Wellpath
Marcus Harris, Regional Health Services Manager, The GEO Group, Inc.
Anastasia Bartle, Staff Services Manager II, PPCMU, Field Operations, Corrections Services, CCHCS

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

PRIVATE PRISON COMPLIANCE AND HEALTH CARE MONITORING AUDIT

Limited Review

Golden State Modified Community Correctional Facility

December 4 – 5, 2018

TABLE OF CONTENTS

DATE OF REPORT

February 5, 2019

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. The process is divided into phases; a remote phase and an onsite phase. The remote phase consists of a review of various documents obtained from the facility including health records, monitoring logs, staffing rosters. The onsite phase involves staff and patient interviews and a tour of all health care service points within the facility.

In accordance with the Receiver's directive, staff from the Private Prison Compliance and Monitoring Unit (PPCMU), Field Operations, Corrections Services conduct an annual audit of each contracted facility located in and out-of-state using the Private Prison Compliance and Health Care Monitoring Audit Instruction Guide. Based upon the percentage of compliance achieved per component and the overall score, the facility may undergo a follow-up limited review or a complete re-audit scheduled six months after the date of the annual audit. This second audit evaluates all components rated Inadequate and the critical issues in order to gauge progress toward improving compliance.

EXECUTIVE SUMMARY

An annual health care monitoring audit was conducted at Golden State Modified Community Correctional Facility (GSMCCF) on May 22 through 24, 2018. The audit review period was December 2018 through March 2018. The patient population at the time was 690 and the facility's budgeted capacity was 700[1]. The facility received an overall compliance rating of *Adequate,* (80.0%) based on the scores compiled from each of the 14 components. Eight components received a rating of Inadequate[2], and 23 critical issues were identified. As a result of failing one or more components, a limited review audit was scheduled six months after the annual audit.

The PPCMU audit team conducted a limited review audit at GSMCCF on December 4 and 5, 2018. The audit review period is June 2018 through September 2018. The patient population at the time of the

[1] Data from CDCR's Weekly Population Count report, dated May 18, 2018.

[2] Two of the eight components, (14. *Quality of Nursing Performance* and 11. *Preventive Services*) are only reviewed during the annual audit. Subsequently these two components are not part of this limited review.

onsite audit was 672 and the facility's budgeted capacity was 683.[3] The audit team consisted of the following personnel:

- R. Delgado, Medical Doctor, Retired Annuitant
- S. Fields, Nurse Consultant, Program Review (NCPR), Retired Annuitant
- S. Carroll, Health Program Specialist

The scope of the limited review included re-examination of:

- Six components, inclusive of both clinical case reviews and quantitative reviews
  - Component 1, *Administrative Operations.*
  - Component 2, *Internal Monitoring and Quality Management.*
  - Component 4, *Access to Care.*
  - Component 6, *Emergency Services and Community Hospital Discharge.*
  - Component 7, *Initial Health Assessment/ Health Care Transfer.*
  - Component 12*, Emergency Medical Response/Drills and Equipment.*
- Twenty-three critical issues identified during the May 2018 audit.

As a result of the limited review audit, auditors found one component improved Proficient, one component improved to Adequate, and four components remained Inadequate. A comparison of the component scores between the May 2018 and December 2018 audits is listed below.

Executive Summary Table

Component	Audit Type	Case Review		Overall Case Review	Quantitative Review	Overall Component
		Nurse	Provider			
1. Administrative Operations	A	N/A	N/A	N/A	74.1%	74.1% *Inadequate*
	LR	N/A	N/A	N/A	74.2%	74.2% *Inadequate*
	+/-				0.1	0.1
2. Internal Monitoring and Quality Management	A	N/A	N/A	N/A	75.3%	75.3% *Inadequate*
	LR	N/A	N/A	N/A	77.2%	77.2% *Inadequate*
	+/-				1.9	1.9
4. Access to Care	A	73.8%	80.0%	76.9%	84.4%	79.4% *Inadequate*
	LR	67.9%	87.5%	77.7%	86.8%	80.7% *Adequate*
	+/-	-5.9	7.5	0.8	2.4	1.3
6. Emergency Services and Community Hospital Discharge	A	50.0%	100.0%	75.0%	N/A	75.0% *Inadequate*
	LR	85.7%	66.7%	76.2%	58.3%	70.2% *Inadequate*
	+/-	+35.7	-33.3	+1.2	N/A	-4.8

[3] Data from CDCR's Weekly Population Count report, dated November 30, 2018.

7. Initial Health Assessment/Health Care Transfer	A	50.0%	100.0%	75.0%	85.7%	78.6% *Inadequate*
	LR	80.0%	100.0%	90.0%	100.0%	93.3% *Proficient*
	+/-	+30.0	0.0	+15.0	+14.3	+14.7
12. Emergency Medical Response/Drills and Equipment	A	N/A	N/A	N/A	79.4%	79.4% *Inadequate*
	LR	N/A	N/A	N/A	64.9%	64.9% *Inadequate*
	+/-				-14.5	-14.5

In addition, the audit team found 13 of the 23 critical issues identified during the annual audit successfully resolved as detailed below, and identified 13 new critical issues.

	Components	Critical Issues	Resolved	Unresolved	New Critical Issues
1.	Administrative Operations	3	2	1	2
2.	Internal Monitoring and Quality Management	4	4	0	6
4.	Access to Care	2	0	2	0
5.	Diagnostic Services	3	2	1	0
6.	Emergency Services and Community Hospital Discharge	0	N/A	N/A	3
7.	Initial Health Assessment/Health Care Transfer	1	1	0	0
8.	Medication Management	2	0	2	0
10.	Specialty Services	2	2	0	0
11.	Preventive Services	2	0	2*	0
12.	Emergency Medical Response/Drills and Equipment	4	2	2	2
	Totals:	**23**	**13**	**10**	**13**

* Indicates critical issues were not evaluated during the limited review. Component 11, Preventative Services evaluates health care services provided on an annual basis (e.g. flu vaccines and tuberculosis screening) and is audited once per year.

IDENTIFICATION OF CRITICAL ISSUES

The table below reflects all quantitative analysis standards in which the facility's compliance fell below acceptable compliance level. During the annual audit, 23 critical issues were identified. During the re-audit, auditors found 13 of the 23 critical issues resolved, ten unresolved, and 13 new critical issues. The table below lists the ten unresolved critical issues from prior audits and the 13 newly identified critical issues from this audit.

Critical Issues – Golden State Modified Community Correctional Center	
Question 1.5	The facility's provider does not access the California Correctional Health Care Services patient electronic health record system regularly. ***This is a new critical issue.***
Question 1.7	The facility does not consistently provide the patient with requested copies of health records within the required time frame. ***This is a new critical issue.***
Question 1.8	The facility does not consistently document the release of health care information on the CDCR Form 7385, *Authorization for Release of Information* when a patient or third party requests the release of health care information. ***This is an unresolved critical issue since the May 2018 audit.***
Question 2.1	The facility does not consistently hold a Quality Management Committee meeting a minimum of once per month. ***This is a new critical issue***.
Question 2.2	The facility's Quality Management Committee's review process does not consistently include a documented corrective action plan for the identified opportunities for improvement. ***This is a new critical issue***.
Question 2.3	The Quality Management Committee's review process does not consistently include monitoring of defined aspect of care. ***This is a new critical issue***.
Question 2.6	The facility does not accurately document all data on the Sick Call Monitoring Log. ***This is a new critical issue***.
Question 2.8	The facility does not accurately document all data on the Chronic Care Monitoring Log. ***This is a new critical issue***.
Question 2.9	The facility does not accurately document all data on the Health Screening Monitoring Log. ***This is a new critical issue***.
Question 4.7	The patients' chronic care follow-up visits are not consistently completed as ordered. ***This is an unresolved critical issue since the May 2018 audit.***
Question 4.8	The facility does not regularly conduct and adequately document a Daily Care Team Huddle during all business days. ***This is an unresolved critical issue since the March 2017 audit.***
Question 5.2	The facility does not consistently complete diagnostic tests within the time frame specified by the primary care provider. ***This is an unresolved critical issue since the May 2018 audit.***
Question 6.1	The registered nurse does not consistently review the discharge plan/instructions upon patient's return. ***This is a new critical issue***.
Question 6.2	The registered nurse does not consistently complete a face-to-face assessment prior to the patient being re-housed. ***This is a new critical issue***.
Question 6.3	The facility's primary care provider does not consistently see the patients for a follow-up appointment within five calendar days of return. ***This is a new critical issue***.
Question 8.1	The chronic care medications are not consistently received by the patient within the required time frame. ***This is an unresolved critical issue since the March 2017 audit.***
Question 8.4	The facility does not administer the prescribed anti-Tuberculosis medications to the patients. This deficiency was not reviewed during the November 2017 and the current audit

	due to unavailability of samples meeting the criteria for this question. ***This is an unresolved critical issue since the March 2017 audit.***
Question 11.1	The facility's nursing staff does not consistently screen for signs and symptoms of tuberculosis, and administer a Tuberculin Skin Test, if indicated, annually. ***This is an unresolved critical issue since the May 2018 audit.***
Question 11.3	The facility does not consistently offer colorectal cancer screening to the patient population 50 to 75 years of age. ***This is an unresolved critical issue since the May 2018 audit.***
Question 12.3	The facility does not consistently hold an Emergency Medical Response Review Committee meeting a minimum of once per month. ***This is a new critical issue***.
Question 12.4	The Emergency Medical Response Review Committee does not consistently perform timely incident package reviews utilizing the required documents. ***This is an unresolved critical issue since the May 2018 audit.***
Question 12.8	The facility's Emergency Medical Response Bag does not contain all the supplies identified on the facility's Emergency Medical Response Bag Checklist. ***This is a new critical issue***.
Question 12.15	The facility does not accurately utilize a naloxone[4] (Narcan) log to account for the use and storage of intranasal naloxone in the facility. ***This is an unresolved critical issue since the May 2018 audit.***

The unresolved critical issues identified above will be monitored for compliance during subsequent audits.

[4] Naloxone - medication administered via injection or nasally that blocks or reverses the effects of opioid medication, including extreme drowsiness, slowed breathing, or loss of consciousness. Naloxone is used to treat a narcotic overdose in an emergency situation.

LIMITED REVIEW AUDIT FINDINGS – FULL COMPONENT AUDIT

During the May 2018 annual audit, eight components received an *Inadequate* overall component rating. Per the audit methodology contained in the *Private Prison Compliance and Health Care Monitoring Audit Instruction Guide (Revised November 2017)*, all sections of these components are reviewed during the limited review. Component 11, *Preventive Services,* and Component 14, *Quality of Nursing Performance* are reviewed annually and therefore are not part of this limited review. Below are the findings for Components 1, 2, 4, 6, 7, and 12.

1 –ADMINISTRATIVE OPERATIONS

This component determines whether the facility's policies and local operating procedures (LOP) are in compliance with Inmate Medical Services Policies & Procedures (IMSP&P) guidelines and the contracts and service agreements for bio-medical equipment maintenance and hazardous waste removal are current. This component also focuses on the facility's effectiveness in filing, storing, and retrieving medical records and medical-related information, as well as maintaining compliance with all Health Insurance Portability and Accountability Act requirements.

Case Review Score:
Not Applicable
Quantitative Review Score: *74.2%*

Overall Score: 74.2%

The compliance for this component is evaluated by auditors through the review of patient medical records and the facility's policies and LOPs. Since no clinical case reviews are conducted to evaluate this component, the overall score is based entirely on the results of the quantitative review.

Quantitative Review Results

During the annual audit, the facility received an overall compliance score of 74.1% (*Inadequate*) with three critical issues identified. During the limited review, the facility received a similar compliance score of 74.2% (Inadequate). Of the eight questions reviewed, four were rated *Proficient,* one was rated *Adequate* and three were rated *Inadequate*. Two of the three prior critical issues were resolved and two new critical issues were identified.

During the annual audit, 6 out of 15 facility LOPs did not comply with IMSP&P resulting in a compliance score of 60.0% (*Inadequate*) (Question 1.2). During the limited review, three of the six non-compliant LOPs were found revised and are now compliant with IMSP&P. This resulted in a compliance score of 80.0% (*Adequate*). This critical issue is resolved. Discussion of the specific deficiencies is documented below.

- Emergency Medical Response and Drills (GSMCCF document number A-1200b)
    - During the limited review the NCPR auditor found this LOP remains non-compliant as it was not updated to include all the forms required to be completed when evaluating emergency medical responses or drills. A list of required forms may be found in IMSP&P, Volume 4, Chapter 12.8, *Emergency Medical Response: Post Event Review Procedure*.

- Medication Management (GSMCCF document number G-1000b)
    - During the limited review the NCPR auditor found this LOP remains non-compliant as it does not indicate the time frames required for making medication available to the patient. Per IMSP&P Volume 4, Chapter 11.4, Medication Administration Procedure, and Volume 4, Chapter 11.2, Medication Orders-Prescribing Procedure.
- Narcan Use and Storage (GSMCCF document number A-1200a)
    - During the limited review, the NCPR auditor found the facility still does not have a dedicated LOP on Narcan Use and Storage.

During the annual review, auditors found the facility's patient orientation handbook did not adequately explain the health care grievance process (Question 1.4). During the limited review, the auditors found the handbook/manual had been updated and is now compliant. This critical issue has been resolved.

During the limited review onsite visit, the PCP explained he does not regularly access the electronic medical record system (Question 1.5), and instead relies on medical staff to provide hardcopies of the patient file. Additionally, auditors found none of the medical staff had access to the electronic health records and the PCP could not log onto the electronic health record system. All staff were provisioned access, although due to inactive use of the system their accounts were suspended per CCHCS IT policy. This is a new critical issue.

During the limited review, auditors found the facility does not consistently provide requested copies of medical records to the patient (Question 1.7). Twenty requests entered on the Release of Information Log were reviewed, of which 13 could not be validated by auditors. This is a new critical issue.

In addition, auditors noted the facility does not consistently utilize the CDCR Form 7385, Authorization for Release of Information to document requests (Question 1.8). During the annual audit, auditors found 13 of the 17 requests were document on the form, resulting in 76.5% compliance. During the limited review, 15 out of 19 requests were documented on the CDCR Form 7385, resulting in 78.9% compliance. This remains a critical issue.

2 –INTERNAL MONITORING AND QUALITY MANAGEMENT

Case Review Score:
Not Applicable
Quantitative Review Score: *77.2 %*
Overall Score: 77.2%

This component focuses on whether the facility completes internal reviews and holds committee meetings in compliance with CCHCS policies. Auditors review minutes from Quality Management Committee meetings to determine if the facility identifies opportunities for improvement; implements action plans to address identified deficiencies; and continuously monitors the quality of health care provided to patients. Auditors also review the monitoring logs utilized by the facility to document and track all patient medical encounters such as initial intake, health assessment, sick call, chronic care, emergency, and specialty care services. These logs are reviewed by for accuracy and timely submission to CCHCS. Lastly, auditors evaluate whether the facility promptly processes and appropriately addresses health care grievances.

The clinical case reviews are not conducted for this component; therefore, the overall component score is based entirely on the results of the quantitative review.

Quantitative Review Results

During the annual audit, the facility received an overall compliance score of 75.3% (*Inadequate*) with four critical issues identified. During the limited review, the facility received an overall compliance score of 77.2% (*Inadequate*), an increase of 1.9 percentage points from the annual audit. Of the 13 questions reviewed, 4 were rated Proficient, 3 were rated Adequate, and 6 were rated Inadequate. The four prior critical issues were resolved; however, six new critical issues were identified. Discussion of this component's critical issues are documented below.

During the limited review audit, the auditor found the facility did not consistently hold Quality Management Committee (QMC) meetings during the audit review period (Question 2.1). QMC meetings were conducted for two out of the four months in the audit review period (July and September), resulting in 50.0% compliance. This is a new critical issue.

Upon review of the two months of meeting minutes, the July meeting minutes were identified as deficient for not including a documented corrective action plan for identified opportunities for improvement (Question 2.2), and not addressing defined aspects of care (Question 2.3). This resulted in a compliance score of 50.0% for both questions and the identification of two new critical issue.

During the annual audit, the facility did not consistently submit the required monitoring logs by the scheduled due dates (Question 2.4) resulting in 79.7% compliance. During the limited review audit, auditors found the facility improved their timeliness by submitting 52 out 62 logs by the scheduled due date, resulting in a compliance score of 83.9%. This critical issue is resolved.

During the limited review, all monitoring logs were audited. The auditor found the Specialty Care (Question 2.6), Chronic Care (Question 2.8), and Intake Screening (Question 2.9) monitoring logs contained several deficiencies. The logs had entries with missing or incorrect dates, with no supporting documentation in EHRS, and/or missing information. This resulted in the identification of three new critical issues. The Hospital Stay/Emergency Department Monitoring Log which was found inaccurate (Question 2.7) during the annual audit, was accurate with all entries complete. This critical issue is resolved.

During the annual audit, the facility's Institutional Level Health Care Grievance Log was not updated to reflect the changes to the grievance decision selection (Question 2.12). During the limited review, the auditor found the facility updated their log. This critical issue has been resolved.

During the annual audit, the auditor identified one of the two grievances submitted during the review period was responded to past the 45 business day time frame (Question 2.13). During the limited review, all grievance responses were completed within the required time frame. This critical issue is resolved.

Recommendation:

- Continue monthly QMC meetings, and improve on documenting discussions and plans for improvement in the meeting minutes. The current minutes were lacking substantive detail.

4 –ACCESS TO CARE

This component evaluates the facility's ability to provide patient population with timely and adequate medical care. The areas of focus include, but are not limited to: nursing practice and documentation, timeliness of clinical appointments, acute and chronic care follow-ups, face-to-face nurse appointments, provider referrals from nursing lines, daily care team huddles, and timely triage of sick call requests. Additionally, the auditors perform onsite inspection of housing units and logbooks to determine if patients have a means to request medical services and to confirm there is continuous availability of CDCR Form 7362*, Health Care Services Request*.

Case Review Score: *77.7%*
Quantitative Review Score: *86.8%*
Overall Score: 80.7%

During the annual audit, the facility received an overall compliance score of 79.4% (Inadequate) with two critical issues identified. During the limited review, the facility received a score of 80.7%, an increase of 1.3 percentage points. Specific findings for the nurse and physician case reviews, and the health record review are documented below.

Case Review Results

During the annual audit, the facility received an overall case review score of 76.9% (*Inadequate*). During the limited review, the facility received a score of 77.7% (*Inadequate*), an increase of 0.8 percentage points.

Nurse Case Reviews

During the annual audit, the facility received a compliance score of 73.8%. For the limited review, the facility received a compliance score of 67.9%, a decrease of 5.9 percentage points. The NCPR auditor reviewed 28 nursing encounters and identified nine deficiencies. The specific deficiencies identified during the limited review are:

- **In Case 16,** three deficiencies were identified. On July 18, 2018, September 5, 2018, and September 22, 2018, the patient was seen by the facility's RN. The documentation for these encounters contained an inadequate objective assessment of the patient's affected area. For the July 18 encounter, the RN should have considered an urgent referral to the PCP instead of routine. For the September 22 encounter, the documentation is lacking measurements of the wound area.
- **In Case 22,** the documentation for the RN encounter on August 14, 2018, contains an incomplete assessment and description of the insect bite.
- **In Care 23,** two deficiencies were identified. There is an incomplete assessment and documentation for the RN encounter on September 1, and inadequate urgent RN referral to the PCP. Nursing staff did not follow-up on the referral and the patient was not seen by the PCP until five days later on September 6, 2018. Urgent referrals must be seen by the PCP within 24 hours per IMSP&P Volume4, Chapter 1.3, Scheduling and Access to Care Procedure.
- **In Case 24,** On September 21, 2018, the patient reported pain in his feet. The documentation from the RN was incomplete and did not reference the type of shoes the patient was wearing,

what makes the pain decrease, if a pedal pulse5 was performed, or if education was provided to the patient related to the complaint.

Physician Case Reviews

During the annual audit, the facility received a compliance score of 80.0%. For the limited review, the facility received a score of 87.5%, an increase of 7.5 percentage points. The physician auditor reviewed 32 provider encounters and identified four deficiencies. The specific provider deficiencies identified during the limited review are:

- **In Case 1**, on June 22, 2018, the patient was seen by the PCP for recurrence of migraine headache. Continued on low dose of propranolol and started on Imitrex. Starting the patient on Imitrex is appropriate however, continuing the low dose of propranolol is inadequate for prophylaxis6.
- **In Case 3**, on July 26, 2018, the patient was seen by the provider for treatment of toenail fungal infection. Antifungal medication was unnecessarily prescribed. Treatment of toenail fungal infection is considered cosmetic unless documentation is provided of a serious infection or serious co-morbidity.
- **In Case 5**, on July 31, 2018, the patient was seen by the PCP for exacerbation of chronic back pain. The PCP's documentation had no mention of "red flag indicators7" this might indicate a more serious condition. No diagnosis was given aside from symptoms of lower back pain. The patient was scheduled to be seen in three weeks, but was not seen until seven weeks later on September 19, 2018.
- **In Case 12**, on September 7, 2018, the patient was seen by the PCP to review lab studies regarding the patient's diabetes and hyperlipidemia. This visit should have included an American College of Cardiology8 10-year Heart Risk Assessment, would have revealed high dose statin is indicated and the use of low dose aspirin is not indicated and should have been discontinued.

Quantitative Review Results

During the annual audit, the facility received a quantitative compliance score of 84.4% (*Adequate*) with two critical issues identified. During the limited review, the facility received a score of 86.8% (*Adequate*). This is an increase of 2.4 percentage points from the annual audit. Both critical issues remain unresolved. Discussion of this component's critical issues are documented below.

During the annual audit and limited review, the auditor found the facility was not consistently completing chronic care follow up visits as ordered (Question 4.7). During the limited review, the NCPR auditor reviewed 16 patient electronic health records and identified nine were completed as ordered resulting in a compliance score of 46.8%. This remains a critical issue.

During the annual audit and limited review, the auditor found the facility was not consistently conducting nor properly documenting Care Team Huddles (Question 4.8). During the limited review, the NCPR auditor

[5] Pedal Pulse – the pulse point is located on the top of the foot, posterior to the toes. A diminished foot pulse may be the only clue that a patient is at increased risk of cardiovascular death.

[6] Prophylaxis – measures designed to preserve health and prevent the spread of disease.

[7] Information regarding red flag indicators can be found on the website at www.consultant360.com.

[8] American College of Cardiology – is a nonprofit medical association established in 1949. The mission of this organization is to transform cardiovascular care and to improve heart health.

reviewed the huddle documents for 19 business days during the month of September. The NCPR auditor found the documentation was complete for 11 of the 19 days, resulting in a compliance score of 57.9%. This critical issue remains unresolved.

Recommendation:

- Develop a huddle script for use each day, and ensure the Health Services Administrator (HSA) attends the huddle regularly. The huddle should include, but is not be limited to, a status report on all patients sent out for higher level of care.

6 –EMERGENCY SERVICES AND COMMUNITY HOSPITAL DISCHARGE

This component evaluates the facility's ability to complete timely follow-up appointments on patients discharged from a community hospital. Some areas of focus are the nurse face-to-face evaluation of the patient upon the patient's return from a community hospital or hub institution, timely review of patient's discharge plans, and timely delivery of prescribed medications.

Case Review Score: *76.2%*
Quantitative Review Score: *58.3%*
Overall Score: 70.2%

The auditors evaluate the emergency medical response system and the facility's ability to provide effective and timely responses. The clinical auditors assess the timeliness and adequacy of the medical care provided based on the patient's emergency situation, clinical condition, and need for a higher level of care.

During the annual audit, the facility received an overall compliance score of 75.0% (*Inadequate*). As a result of the limited review, GSMCCF achieved a score of 70.2% (*Inadequate*). This is a decrease of 4.8 percentage points. Specific findings for the nurse and physician case reviews, and the quantitative review are documented below.

Case Review Results

During the annual audit, the facility received an overall case review score of 75.0% (*Inadequate*). During the limited review, the facility received a score of 76.2% (*Inadequate*), an increase of 1.2 percentage points.

Nurse Case Reviews

During the annual audit, the facility received a compliance score of 50.0% (*Inadequate*). For the limited review, the facility received a compliance score of 85.7% (*Adequate*), an increase of 35.7 percentage points. The NCPR auditor reviewed seven nursing encounters and identified one deficiency. The specific deficiency identified during the limited review is:

- **In Case 19**, on August 29, 2018, the patient was involved in an altercation resulting in a facial laceration. A CDCR Form 7463, First Medical Responder-Data Collection Tool, was utilized during the nursing encounter; however, the interventions section of the tool was incomplete. The patient's electronic health record lacked documentation related to the patient's injuries.

Physician Case Reviews

During the annual audit, the facility received a compliance score of 100%. For the limited review, the facility received a compliance score of 66.7%, a decrease of 33.3 percentage points. The physician auditor reviewed three provider encounters and identified one deficiency. The specific findings of the deficiency identified during limited review is:

- **In Case 07**, on July 19, 2018, the patient received laparoscopic surgery at the hub institution. On July 19, 2018, the patient was seen by the PCP at the hub and medically cleared to return to GSMCCF. However, the patient was not returned to GSMCCF until November 16, 2018, nearly four months later. As of the date of the onsite audit, the patient had still not been seen by the PCP at GSMCCF.

Quantitative Review Results

During the annual audit, none of the samples identified during the audit review period met the criteria for this component; therefore, this component was unable to be reviewed. During the limited review, samples met the criteria and all four questions for this component were evaluated resulting in a score of 58.3% (*Inadequate*) with three new critical issues identified. Of the four questions reviewed, one was rated *Proficient* and three were rated *Inadequate*. Discussion of this component's critical issue is documented below.

During the limited review, the NCPR auditor identified the facility's nursing staff did not consistently review the discharge plans/instructions of patients returning from a community hospital (Question 6.1) or complete a face to face assessment prior to the patient being rehoused (Question 6.2). The NCPR auditor found one out of three patient electronic health records contained documentation noting review of the discharge plans/instructions, and two out three patients received a face-to-face assessment, resulting in a compliance of score of 33.3% and 66.7%, respectively. These are two new critical issue. Lastly, the NCPR auditor found patients were not consistently seen by the PCP for a follow-up appointment within five calendar days of the patient's return (Question 6.3). The NCPR found one out of three patients saw the PCP timely, resulting in a compliance score of 33.3%. This is also a new critical issue.

7 –INITIAL HEALTH ASSESSMENT/HEALTH CARE TRANSFER

Case Review Score: *90.0%*
Quantitative Review Score: *100.0%*
Overall Score: 93.3%

This component determines whether the facility adequately manages patients' medical needs and continuity of patient care during inter- and intra-facility transfers by reviewing the facility's ability to timely: perform initial health screenings, complete required health screening assessment documentation (including tuberculin screening tests), and deliver medications to patients received from another facility. Also, for those patients who transfer out of the facility, this component reviews the facility's ability to accurately and appropriately document transfer information that includes pre-existing health conditions, pending medical, dental and mental health appointments, medication transfer packages, and medication administration prior to transfer.

During the annual audit, the facility received an overall compliance score of 78.6% (*Inadequate*). As a result of the limited review, GSMCCF achieved an overall compliance score of 93.3% (*Proficient*). This is an increase of 14.7 percentage points. Specific findings for the nurse and physician case reviews, and the quantitative review are documented below.

Case Review Results

During the annual audit, the facility received an overall case review score of 75.0% (*Inadequate*). During the limited review, the facility received a score of 90.0% (*Proficient*), an increase of 15.0 percentage points.

Nurse Case Reviews

During the annual audit, the facility received a compliance score of 50.0% (*Inadequate*). For the limited review, the facility received a compliance score of 80.0% (*Adequate*). This is an increase of 30.0 percentage points. The NCPR auditor reviewed ten nursing encounters and identified two deficiencies. The specific deficiencies identified during the limited review are:

- **In Case 16**, the facility RN did not sign the off-site return face-to-face assessment form.
- **In Case 19**, the facility RN did not document an assessment of the scope or resolution of the patient's injuries upon his return to the facility.

Physician Case Reviews

During the both the annual and limited review audits, the facility received a compliance score of 100% (*Proficient*).

Quantitative Review Results

During the annual audit, the facility received a quantitative compliance score of 85.7% (*Adequate*) with one critical issue identified. During the limited review, all eight component questions were re-evaluated and the facility received a quantitative compliance score of 100% (*Proficient*). This is an increase of 14.3 percentage points from the annual audit. The one prior critical issue was resolved. Discussion of this component's critical issue is documented below.

During the annual audit, the facility's nursing staff were unable to identify what is to be included in the Transfer Envelope (Question 7.8), resulting in a 0.0% compliance score. During the limited review, the NCPR auditor interviewed the nursing staff and found all were able to identify the required forms and knew the type of medications required to be included in the Transfer Envelope. This resulted in a compliance score of 100%. This is an increase of 100 percentage points from the previous score. This critical issue is resolved.

12 –EMERGENCY MEDICAL RESPONSE/DRILLS and EQUIPMENT

Case Review Score: *Not Applicable*
Quantitative Review Score: *64.9%*
Overall Score: 64.9%

For this component, the NCPR auditors review the facility's emergency medical response documentation to assess the response time frames of facility's health care staff during medical emergencies and/or drills. The NCPR auditors also inspect emergency response bags and various emergency medical equipment to ensure regular inventory and maintenance of equipment is occurring. The compliance for this component is evaluated entirely through the review of emergency medical response documentation, inspection of emergency medical response bags and crash carts, and inspection of medical equipment located in the clinics.

The clinical case reviews are not conducted for this component; therefore, the overall component score is based entirely on the results of the quantitative review.

Quantitative Review Results

During the annual audit, the facility received an overall compliance score of 79.4% (*Inadequate*) with four critical issues identified. During the limited review, the facility received a compliance score of 64.9% (Inadequate), a decrease of 14.5 percentage point. Of the eight questions reviewed, four were rated *Proficient* and four were rated *Inadequate*. Two of the four prior critical issues were resolved and two new critical issues were identified.

During the annual audit, the facility did not consistently conduct emergency medical response drills quarterly on each shift (Question 12.1) resulting in a compliance score of 66.7%. During the limited review, the auditor found the facility completed at least one emergency medical response drill on each shift during the most recent quarter, resulting in a compliance score of 100%. This critical issue is resolved.

During the annual audit, the facility did not consistently document whether an RN or provider responded to an emergency medical alarm within the specified time frame (Question 12.2), resulting in a compliance score of 63.6%. During the limited review, the auditor found the facility had documented the response times of the RN or provider for all emergency medical responses and drills during the audit review period, resulting in a compliance score of 100%. This critical issue is resolved.

During the annual audit, the facility was compliant with holding an EMRRC Meeting each month during the audit review period (Question 12.3). However, during the limited review, the facility held an EMRRC Meeting two out of the four months of the audit review period. There were no meeting minutes for the months of June and July 2018 to validate a meeting was held. This is a new critical issue.

During the annual audit and limited review, the NCPR auditor found the facility did not consistently perform timely incident package reviews (Question 12.4). During the limited review, the auditor found the six drills held in August and September 2018 were not reviewed during the EMRRC meetings held on August 29, and September 28, 2018. This remains a critical issue.

During the limited review, the NCPR auditor reviewed the contents of the EMR Bag and were not able to find the shears (scissors) (Question 12.8). The EMR Bag also contained Narcan, which was not listed on the EMR Bag Checklist. This is a new critical issue.

During the annual and limited review, auditors found the facility did not maintain a designated Narcan Accountability Log for staff to account for the Narcan at the beginning and end of each shift (Question 12.15). This critical issue remains unresolved. The facility did provide a log for October, which was outside of the audit review period. Auditors noted the following deficiencies:

- The log is designed for three 8-hour shifts but nursing staff are working two 12-hour shifts.
- The log is incorrectly labeled Central Valley MCCF.
- The log indicates the oncoming shift nurse is initialing both the outgoing and oncoming nurse, indicating there is no cross check of a second nurse.
- The log entry for October 23, 2018, indicates the same nurse signed the Narcan log for the entire 24-hour period.

LIMITED REVIEW – PARTIAL COMPONENT AUDIT

During the annual audit conducted in May 2018, the auditor found the nurse case review rating for the Medical/Medication Management component to be *Inadequate* and identified 23 critical issues. During the limited review, auditors found the case review rating was proficient and 13 critical issues resolved. Two critical issues were unable to be rated. The facility's progress in resolving the critical issues associated with Components 1, 2, 4, 6, 7, and 12 are discussed in the preceding sections, Limited Review – Full Component Audit. The remainder of the critical issues are discussed below.

5 – DIAGNOSTIC SERVICES

Quantitative Review

During the annual audit, the facility received a quantitative compliance score of 78.6% *(Inadequate*) with three critical issue identified for this component.

1. The facility does not consistently complete diagnostic tests within the time frame specified by the primary care provider. (Question 5.2)

Prior Compliance	Current Compliance	Status
72.7%	75.0%	**Unresolved**

During the annual audit, the NCPR auditor reviewed 11 patient electronic health records and found eight records deficient. During the limited review, the NCPR auditor reviewed 12 records and found the facility did not complete the diagnostic test for three of the tests. This remains a critical issue.

2. The primary care provider does not consistently review, sign, and date patient diagnostic test reports within two business days of receipt. (Question 5.3)

Prior Compliance	Current Compliance	Status
75.0%	91.7%	**Resolved**

During the annual audit, the NCPR auditor reviewed 12 patient electronic health records and found three records deficient. During the limited review, the NCPR auditor reviewed 12 records and identified the diagnostic test result of one patient was not reviewed. This critical issue is now resolved.

3. The facility does not consistently provide patients with written notification of their diagnostic test results within two business days of receipt of results. (Question 5.4)

Prior Compliance	Current Compliance	Status
75.0%	91.7%	**Resolved**

During the annual audit, the NCPR auditor reviewed 12 patient electronic health records and found three records deficient. During the limited review, the NCPR auditor reviewed 12 records

and identified one patient was not provided written notification of their diagnostic test results. This critical issue is now resolved.

8 – MEDICAL/MEDICATION MANAGEMENT

Nurse Case Review

During the annual audit, the NCPR auditor reviewed 58 nursing encounters and identified 12 deficiencies receiving a compliance score of 79.3%. For the limited review, the NCPR auditor reviewed 43 nursing encounters and did not identify any deficiencies. This is an increase of 20.7 percentage points. While reviewing the nursing encounters, the NCPR auditor identified one of the nursing staff does not consistently complete part II of the CDCR Form 7362, *Health Care Services Request Form*.

Quantitative Review

During the annual audit, the facility received a quantitative compliance score of 85.4% *(Adequate*) with two critical issue identified.

1. The chronic care medications are not consistently received by the patient within the required time frame. (Question 8.1)

Prior Compliance	Current Compliance	Status
6.3%	68.8%	**Unresolved**

During the annual audit, the NCPR auditor reviewed 16 patient electronic health records and found 15 records deficient. During the limited review, the NCPR auditor reviewed 16 records and found five patients did not receive their chronic care medications within the required time frame. This critical issue remains unresolved.

2. The facility does not administer the prescribed anti-Tuberculosis medications to patients. (Question 8.4)

Prior Compliance	Current Compliance	Status
N/A	0.0%	**Unresolved**

This critical issue was initially identified during the March 2017 audit. During the annual audit in May 2018, no patients met the criteria for this question. During the limited review, one patient meeting the criteria was identified. The NCPR auditor was unable to find any documentation the patient received the prescribed anti-Tuberculosis medication(s). This critical issue remains unresolved.

Recommendations:

- Prescribing long-term non-steroidal anti-inflammatory drugs (NSAIDs[9]) should be minimized. If determined to be medically necessarily, a detailed note documenting its necessity should be placed in the patient's record, explaining the how the benefits outweigh the risk.
- The PCP is encouraged to advocate on behalf of the patient. If the PCP believes medications were inappropriately denied, the PCP shall appeal to a higher level as appropriate.

10 – SPECIALTY SERVICES

Quantitative Review

During the annual audit, the facility received a quantitative compliance score of 60.7% *(Inadequate*) with two critical issues identified for this component.

1. Upon the patient's return from the specialty service appointment, the facility RN does not consistently complete a face-to-face assessment prior to the patient's return to their assigned housing unit. (Question 10.2)

Prior Compliance	Current Compliance	Status
71.4%	100.0%	**Resolved**

During the annual audit, the NCPR auditor reviewed seven patient electronic health records and found two records deficient resulting in a 71.4% compliance score. During the limited review, there were no deficiencies identified, resulting in a compliance score of 100%. This critical issue is now resolved.

2. The facility RN does not notify the facility provider of any immediate medication or follow-up appointments recommended by the specialty consultant, upon the patients' return from specialty care appointments. (Question 10.3)

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

During the annual audit, the NCPR auditor reviewed three patient electronic health records and found all three as deficient resulting in a 0.0% compliance score. During the limited review, the NCPR auditor reviewed four records and found the facility's RN notified the PCP in each record. This critical issue is now resolved.

Recommendations:

- Facility patients who are at the hub institution for specialty services should be tracked by medical staff at GSMCCF. The facility should make regular, repeated contact with the Utilization

[9] NSAIDs - Nonsteroidal anti-inflammatory drugs are a drug class that reduce pain, decrease fever, prevent blood clots and, in higher doses, decrease inflammation. Side effects depend on the specific drug, but largely include an increased risk of gastrointestinal ulcers and bleeds, heart attack and kidney disease

Management nurse at the hub to discuss the patient's status and earliest possible return date to the facility.

- The PCP is encouraged to advocate on behalf of a patient. If the PCP believes a request for services was inappropriately denied, the PCP shall appeal to a higher level as appropriate as outlined in IMSP&P Volume 4 Chapter 34.2, Utilization Management Medical Services Review Procedure.

CONCLUSION

During the limited review audit, Components 1, 2, 4, 6, 7, and 12, were re-evaluated in addition to the 23 critical issues identified during the May 2018 Annual Audit. As a result, one out of the six components received a proficient rating, 13 critical issues were found resolved, and 13 new critical issues were identified.

The facility showed improvement in one out of the six components re-evaluated. Component 7, *Initial Health Assessment/Health Care Transfer* received an overall component rating of Proficient. The facility continues to struggle with achieving compliance in the other components. The areas of non-compliance are as follows:

- Monthly QMC meetings are not consistently held. When they are held, the meeting minutes lack documentation of discussions relating to corrective action items or monitoring for identified opportunities for improvement.
- Monthly monitoring logs are not consistently accurate.
- Chronic care visits are not consistently complete as ordered.
- Nursing staff does not consistently review the discharge plans/instructions or complete a face-to-face assessment upon a patient's return to the facility, and the PCP does not consistently see the patient within five calendar days of return.
- The facility does not consistently hold monthly EMRRC meetings, nor does the EMRRC perform timely incident package reviews utilizing the required documents.
- The EMR Bag does not contain all the supplies identified on the EMR Bag Checklist, nor does the facility utilize a dedicated log to account for the use and storage of Narcan at the facility.

At the conclusion of the audit, the auditors discussed the preliminary limited review audit findings and recommendations with GSMCCF custody and health care management. A discussion of patient refusal of appointments at the hub institution because of the perceived delay in returning to the MCCF after the appointment was discussed in length. The audit team recommended the health care staff take a more proactive role in monitoring these offsite appointments and to contact the hub staff regularly to facilitate the patient's timely return to GSMCCF. The staff at GSMCCF were receptive to the findings, suggestions, and recommendations presented by the auditors.

APPENDIX A – QUANTITATIVE REVIEW RESULTS

1. Administrative Operations		Audit Type	Yes	No	Compliance	Change
1.1	Does health care staff have access to the facility's health care policies and procedures and know how to access them?	A	5	0	100.0%	0.0
		LR	5	0	100.0%	
1.2	Does the facility have current and updated written health care policies and local operating procedures that are in compliance with *Inmate Medical Services Policies and Procedures* guidelines?	A	9	6	60.0%	+20.0
		LR	12	3	80.0%	
1.3	Does the facility have current contracts/service agreements for routine oxygen tank maintenance service, hazardous waste removal, and repair, maintenance, inspection, and testing of biomedical equipment?	A	3	0	100.0%	0.0
		LR	3	0	100.0%	
1.4	Does the patient orientation handbook/manual or similar document explain the sick call and health care grievance processes?	A	0	1	0.0%	+100.0
		LR	1	0	100.0%	
1.5	Does the facility's provider(s) access the California Correctional Health Care Services patient electronic medical record system regularly?	A	0	0	N/A	N/A
		LR	0	1	0.0%	
1.6	Does the facility maintain a Release of Information log that contains ALL the required data fields and all columns are completed?	A	1	0	100.0%	0.0
		LR	1	0	100.0%	
1.7	Did the facility provide the requested copies of medical records to the patient within 15 business days from the date of the initial request?	A	14	3	82.4%	-47.4
		LR	7	13	35.0%	
1.8	Are all patient and/or third party written requests for health care information documented on a CDCR Form 7385, *Authorization for Release of Information*, and copies of the forms filed in the patient's electronic medical record?	A	13	4	76.5%	+2.4
		LR	15	4	78.9%	
	Overall Percentage Score and Change:		**Annual**		**74.1%**	**+0.1**
			Limited Review		**74.2%**	

Comments:

1.2 The Emergency Medical Response and Drills, Medication Management, and Narcan Use and Storage LOPs remain non-compliant with IMSP&P.

1.5 The primary care provider does not access the CCHCS electronic unit health record regularly and was unable to log on during the onsite audit.

1.7 The auditor reviewed 20 requests by patients for health records during the audit review period. The auditor was unable to verify 13 patients received the records within the required time frame.

- Three entries indicated health records were provided to the patients however, documentation corresponding to the request could not be located
- Eight entries had documentation in EHRS but lacked any indication of the date or the number of records provided to the patients.
- One entry stated the request was not fulfilled because the facility's health care staff do not have access to health records prior CDCR's transition to EHRS, this is not correct.
- One entry had an incorrect CDCR number.

2. Internal Monitoring & Quality Management		Audit Type	Yes	No	Compliance	Change
2.1	Did the facility hold a Quality Management Committee meeting a minimum of once per month?	A	4	0	100.0%	-50.0
		LR	2	2	50.0%	
2.2	Did the Quality Management Committee's review process include documented corrective action plan for the identified opportunities for improvement?	A	4	0	100.0%	-50.0
		LR	1	1	50.0%	
2.3	Did the Quality Management Committee's review process include monitoring of defined aspects of care?	A	4	0	100.0%	-50.0
		LR	1	0	50.0%	
2.4	Did the facility submit the required monitoring logs by the scheduled date per Private Prison Compliance and Monitoring Unit program standards?	A	47	12	79.7%	+4.2
		LR	52	10	83.9%	
2.5	Is data documented on the sick call monitoring log accurate?	A	14	3	82.4%	+17.6
		LR	18	0	100.0%	
2.6	Is data documented on the specialty care monitoring log accurate?	A	12	0	100.0%	-41.7
		LR	7	5	58.3%	
2.7	Is data documented on the hospital stay/emergency department monitoring log accurate?	A	0	3	0.0%	+100.0
		LR	4	0	100.0%	
2.8	Is data documented on the chronic care monitoring log accurate?	A	16	3	84.2%	-19.2
		LR	13	7	65.0%	
2.9	Is data documented on the initial intake screening monitoring log accurate?	A	19	1	95.0%	-20.0
		LR	15	5	75.0%	
2.10	Are the CDCR Forms 602-HC, *Health Care Grievance (Rev. 06/17) and 602 HC A, Health Care Grievance Attachment (Rev. 6/17),* readily available to patients in all housing units?	A	7	1	87.5%	0.0
		LR	7	1	87.5%	
2.11	Are patients able to submit the CDCR Forms 602-HC, *Health Care Grievances,* on a daily basis in all housing units?	A	8	0	100.0%	0.0
		LR	8	0	100.0%	
2.12	Does the facility maintain a Health Care Grievance log that contains all the required information?	A	0	1	0.0%	+100.0
		LR	1	0	100.0%	
2.13	Are institutional level health care grievances being processed within specified time frames?	A	1	1	50.0%	+33.3
		LR	5	1	83.3%	
	Overall Percentage Score and Change:			**Annual**	**75.3%**	**+1.9**
				Limited Review	**77.2%**	

Comments:

2.1 The facility held Quality Management Committee (QMC) Meetings two out of the four months of the audit review period. There were no meeting minutes for the months of June and August 2018 to validate a meeting was held.

2.2 The auditor reviewed the QMC meeting minutes for the months of July and September 2018. The meeting minutes for July 2018 were deficient as they were abbreviated with no corrective action plan follow-up or review documented. Due to the double failure rule, June and August were scored as N/A as they failed Question 2.1.

2.3 The auditor reviewed the QMC meeting minutes for the months of July and September 2018. The meeting minutes for July 2018 lacked detail with no review process included for the monitoring of defined aspects of care. Due to the double failure rule, June and August were scored as N/A as they failed Question 2.1.

2.4 The facility did not consistently submit all the monitoring logs within the required time frame.

2.6 Of the 12 entries evaluated, 5 were identified to be non-compliant. Two dates of PCP referral documented on the referral form did not match the dates documented on the log. The log documented two other entries were still awaiting approval, however, one referral had been denied and the other approved. For the final entry, the auditor was unable to locate a referral form in the electronic health record for the PCP referral date documented on the log.

2.8 Of the 20 entries evaluated, 7 were identified to be non-compliant. Three entries had the incorrect dates transcribed on the log. And four entries had the missing documentation from the electronic health record.

2.9 Of the 20 entries evaluated, 5 were identified to be non-compliant. For the five entries for the month of June 2018, all five were missing the date the patient received their history and physical examination.

4. Access to Care		Audit Type	Yes	No	Compliance	Change
4.1	Did the registered nurse review the CDCR Form 7362, *Health Care Services Request*, or similar form, on the day it was received?	A	15	1	93.8%	+6.2
		LR	16	0	100.0%	
4.2	Following the review of the CDCR Form 7362, or similar form, did the registered nurse complete a face-to-face evaluation of the patient within the specified time frame and document the evaluation in the appropriate format?	A	15	1	93.8%	0.0
		LR	15	1	93.8%	
4.3	Was the focused subjective/objective assessment conducted based upon the patient's chief complaint?	A	16	0	100.0%	0.0
		LR	15	0	100.0%	
4.4	Did the registered nurse implement appropriate nursing action based upon the documented subjective/objective assessment data within the nurse's scope of practice or supported by the standard Nursing Protocols?	A	16	0	100.0%	0.0
		LR	15	0	100.0%	
4.5	Did the registered nurse document that effective communication was established and that education was provided to the patient related to the treatment plan?	A	15	1	93.8%	-7.1
		LR	13	2	86.7%	
4.6	If the registered nurse determined a referral to the primary care provider was necessary, was the patient seen within the specified time frame?	A	10	1	90.9%	-5.2
		LR	12	2	85.7%	
4.7	Was the patient's chronic care follow-up visit completed as ordered?	A	10	6	62.5%	-18.7
		LR	7	9	43.8%	
4.8	Did the Care Team regularly conduct and properly document a Care Team Huddle during business days?	A	2	20	9.1%	+48.8
		LR	11	8	57.9%	
4.9	Does nursing staff conduct daily rounds in segregated housing units and collect CDCR Form 7362, *Health Care Services Request*, or similar forms? (COCF only)	A	N/A	N/A	N/A	N/A
		LR	N/A	N/A	N/A	
4.10	Are the CDCR Forms 7362, *Health Care Services Request,* or similar form, readily accessible to patients in all housing units?	A	8	0	100.0%	0.0
		LR	8	0	100.0%	

4.11	Are patients in all housing units able to submit the CDCR Forms 7362, *Health Care Services Request*, or similar form, on a daily basis?	A	8		100.0%	0.0
		LR	8	0	100.0%	
	Overall Percentage Score and Change:			**Annual**	**84.4%**	**+2.4**
				Limited Review	**86.8%**	

Comments:

4.2 Of the 16 patient health records reviewed, 1 revealed the RN did not complete a face-to-face evaluation of the patient within the specified time frame.

4.5 Of the 15 health records reviewed, 2 did not have documentation the RN established effective communication and provided education to the patient related to the treatment plan.

4.6 Of the 14 health records reviewed of patients referred to the PCP by the RN, 2 revealed the patient was not seen by the PCP within the specified time frame.

4.7 Of the 16 patient health records reviewed, 9 revealed the patient's chronic care follow-up appointment was not completed as ordered.

4.8 The Daily Care Huddle documentation for the 19 business days in September 2018 were reviewed by the auditor. The auditor found the huddle documentation lacked complete and/or follow-up documentation for eight days.

5. Diagnostic Services		Audit Type	Yes	No	Compliance	Change
5.2	Was the diagnostic test completed within the time frame specified by the primary care provider?	A	8	3	72.7%	+2.3
		LR	9	3	75.0%	
5.3	Did the primary care provider review, sign, and date the patient's diagnostic test report(s) within two business days of receipt of results?	A	9	3	75.0%	+16.7
		LR	11	1	91.7%	
5.4	Was the patient given written notification of the diagnostic test results within two business days of receipt of results?	A	9	3	75.0%	+16.7
		LR	11	1	91.7%	

Comments:

5.2 The auditor reviewed 12 health records and found 3 records did not have documentation the diagnostic test(s) was completed within the time frame specified by the primary care provider.

5.3 The auditor reviewed 12 health records and found for one record, the PCP did not review, sign and date the diagnostic test report within the required time frame.

5.4 The auditor reviewed 12 health records and found for one record, the patient did not receive written notification of the diagnostic test result(s) within the required time frame.

6. Emergency Services & Community Hospital Discharge		Audit Type	Yes	No	Compliance	Change
6.1	*For patients discharged from a community hospital:* Did the registered nurse review the discharge plan/instructions upon patient's return?	A	N/A	N/A	N/A	N/A
		LR	1	2	33.3%	
6.2	*For patients discharged from a community hospital:* Did the RN complete a face-to-face assessment prior to the patient being re-housed?	A	N/A	N/A	N/A	N/A
		LR	2	1	66.7%	
6.3	*For patients discharged from a community hospital:*	A	N/A	N/A	N/A	N/A

	Was the patient seen by the primary care provider for a follow-up appointment within five calendar days of return?	LR	2	3	33.3%	
6.4	*For patients discharged from a community hospital:* Were all prescribed medications administered/delivered to the patient per policy or as ordered by the primary care provider?	A	N/A	N/A	N/A	N/A
		LR	1	0	100.0%	
	Overall Percentage Score and Change:			**Annual**	**N/A**	**N/A**
				Limited Review	**70.2%**	

Comments:

6.1 The auditor reviewed three health records and found two records did not have documentation the registered nurse reviewed the discharge plan/instructions upon the patient's return.

6.2 The auditor reviewed three health records and found one record did not have documentation the registered nurse completed a face-to-face assessment of the patient prior to the patient being rehoused.

6.3 The auditor reviewed three health records and found two records did not have documentation the patient was seen by the primary care provider for a follow-up appointment within five calendar days of return.

7. Initial Health Assessment/Health Care Transfer		Audit Type	Yes	No	Compliance	Change
7.1	Did the patient receive an initial health screening upon arrival at the receiving facility by licensed health care staff?	A	12	0	100.0%	0.0
		LR	12	0	100.0%	
7.2	If YES was answered to any of the questions on the *Initial Health Screening* form (CDCR Form 7277/7277A or similar form), did the registered nurse document an assessment of the patient?	A	8	0	100.0%	0.0
		LR	10	0	100.0%	
7.3	If the patient required referral to an appropriate provider based on the registered nurse's disposition, was the patient seen within the required time frame?	A	5	0	100.0%	0.0
		LR	9	0	100.0%	
7.4	If upon arrival, the patient had a scheduled or pending medical, dental, or a mental health appointment, was the patient seen within the time frame specified by the sending facility's provider?	A	N/A	N/A	N/A	N/A
		LR	1	0	100.0%	
7.5	Did the patient receive a complete screening for the signs and symptoms of tuberculosis upon arrival?	A	12	0	100.0%	0.0
		LR	12	0	100.0%	
7.6	Did the patient receive a complete initial health assessment or health care evaluation by the facility's Primary Care Provider within the required time frame upon patient's arrival at the facility?	A	12	0	100.0%	0.0
		LR	12	0	100.0%	
7.7	When a patient transfers out of the facility, are all pending appointments that were not completed, documented on a CDCR Form 7371, *Health Care Transfer Information Form*, or a similar form?	A	5	0	100.0%	0.0
		LR	5	0	100.0%	

7.8	Does the Inter-Facility Transfer Envelope contain all the required transfer documents and medications?	A	0	1	0.0%	+100.0
		LR	3	0	100.0%	
	Overall Percentage Score and Change:			**Annual**	**85.7%**	**+14.3**
				Limited Review	**100.0%**	

Comments:

None

8. Medical/Medication Management		Audit Type	Yes	No	Compliance	Change
8.1	Were the patient's chronic care medications received by the patient within the required time frame?	A	1	15	6.3%	+62.5
		LR	11	5	68.8%	
8.4	*For patients prescribed anti-Tuberculosis medication(s):* Did the facility administer the medication(s) to the patient as prescribed?	A	N/A	N/A	N/A	N/A
		LR	0	1	0.0%	

Comments:

8.1 The auditor reviewed 16 health records and found 5 patients did not receive their chronic care medications within the required time frame.

8.2 The auditor reviewed one record meeting the criteria for this question and found the facility did not administer the TB medication(s) the patient as prescribed.

10. Specialty Services		Audit Type	Yes	No	Compliance	Change
10.2	Upon the patient's return from the specialty service appointment, did the registered nurse complete a face-to-face assessment prior to the patient's return to the assigned housing unit?	A	5	2	71.4%	+28.6
		LR	7	0	100.0%	
10.3	Upon the patient's return from the specialty services appointment, did the registered nurse notify the primary care provider of any immediate medication or follow-up requirements provided by the specialty consultant?	A	0	3	0.0%	+100.0
		LR	4	0	100.0%	

Comments:

None

11. Preventative Services		Audit Type	Yes	No	Compliance	Change
11.1	*For all patients:* Were patients screened annually for signs and symptoms of tuberculosis by the appropriate nursing staff and receive a Tuberculin Skin Test, if indicated?	A	0	20	0.0%	N/A
		LR	N/A	N/A	N/A	
11.3	*For all patients 50 to 75 years of age:* Were the patients offered colorectal cancer screening?	A	8	7	53.3%	N/A
		LR	N/A	N/A	N/A	

Comments:

11.1 through 11.3 These questions evaluate health care services provided on an annual basis (e.g. flu vaccines and tuberculosis screening) and is audited once per year.

12. Emergency Medical Response/Drills & Equipment		Audit Type	Yes	No	Compliance	Change
12.1	Did the facility conduct emergency medical response drills quarterly on each shift when medical staff was present during the most recent full quarter?	A	2	1	66.7%	+33.3
		LR	6	0	100.0%	
12.2	Did a registered nurse, a mid-level provider, or a primary care provider respond within eight minutes after emergency medical alarm was sounded?	A	7	4	63.6%	+36.4
		LR	8	0	100.0%	
12.3	Did the facility hold an Emergency Medical Response Review Committee meeting a minimum of once per month?	A	4	0	100.0%	-50.0
		LR	2	2	50.0%	
12.4	Did the Emergency Medical Response Review Committee perform timely incident package reviews that included the use of required review documents?	A	7	4	63.6%	-63.6
		LR	0	6	0.0%	
12.5	Is the facility's clinic Emergency Medical Response Bag secured with a seal?	A	93	0	100.0%	-1.1
		LR	89	1	98.9%	
12.6	If the emergency medical response and/or drill warranted an opening of the Emergency Medical Response Bag, was it re-supplied and re-sealed before the end of the shift?	A	4	0	100.0%	0.0
		LR	6	0	100.0%	
12.7	Was the Emergency Medical Response Bag inventoried at least once a month?	A	4	0	100.0%	0.0
		LR	4	0	100.0%	
12.8	Did the Emergency Medical Response Bag contain all the supplies identified on the facility's Emergency Medical Response Bag Checklist?	A	1	0	100.0%	-100.0
		LR	0	1	0.0%	
12.9	Was the facility's Medical Emergency Crash Cart secured with a seal? (COCF Only)	A	N/A	N/A	N/A	N/A
		LR	N/A	N/A	N/A	
12.10	If the emergency medical response and/or drill warranted an opening and use of the Medical Emergency Crash Cart, was it re-supplied and re-sealed before the end of the shift? (COCF Only)	A	N/A	N/A	N/A	N/A
		LR	N/A	N/A	N/A	
12.11	Was the Medical Emergency Crash Cart inventoried at least once a month? (COCF Only)	A	N/A	N/A	N/A	N/A
		LR	N/A	N/A	N/A	
12.12	Does the facility's Medical Emergency Crash Cart contain all the medications as required/approved per *Inmate Medical Services Policies and Procedures*? (COCF Only)	A	N/A	N/A	N/A	N/A
		LR	N/A	N/A	N/A	
12.13	Does the facility's Medical Emergency Crash Cart contain the supplies identified on the facility's crash cart checklist? (COCF Only)	A	N/A	N/A	N/A	N/A
		LR	N/A	N/A	N/A	
12.14	Does the facility have the emergency medical equipment that is functional and operationally ready?	A	5	0	100.0%	0.0
		LR	6	0	100.0%	

12.15	Does the facility store naloxone (Narcan) in a secured area within each area of responsibility (medical clinics) and does the facility's health care staff account for the Narcan at the beginning and end of each shift?	A	0	1	0.0%	0.0
		LR	0	1	0.0%	
Overall Percentage Score and Change:				**Annual**	**79.4%**	**-14.5**
				Limited Review	**64.9%**	

Comments:

12.3 The facility held an EMRRC Meeting two out of the four months of the audit review period. There were no meeting minutes for the months of June and July 2018 to validate a meeting was held.

12.4 The auditor reviewed eight incident packages for drills and actual emergency incidents occurring during the audit review period. Two incidents occurred in June 2018, and due to the facility not holding EMRRC meetings in June and July 2018 to review those incidents, they were scored as not applicable, per the double failure rule. The six drills held in August and September 2018 were not discussed in the EMRRC meetings held on August 29 and September 28, 2018.

12.5 The auditor reviewed the EMR Bag Log for the 30 days in September 2018 to ensure health care staff on each shift (3 shifts) verified and documented the seal on the EMR Bag was intact. Of the 90 health care staff initials required, the health care staff initials for the 2nd watch shift on September 13, 2018, were missing.

12.8 The Emergency Medical Response (EMR) Bag did not contain all the supplies identified on the EMR Bag Checklist. The shears were missing from the end pocket and Narcan was found in the bag but was not listed current inventory checklist.

12.15 The facility was unable to provide a Narcan log for September 2018, the last month of the audit review period. The facility provided the October 2018 Narcan Log. The GSMCCF Narcan log was designed for three shifts of eight hours each. The nursing staff at GSMCCF is currently working 12 hour shifts. The log is labeled as Central Valley MCCF instead of Golden State MCCF. The accountability count of the Narcan does not appear to be completed by both the outgoing and oncoming nurse. The oncoming nurse is initialing both areas, indicating there is no cross check of a second nurse. On October 23, 2018, it appears as if the same nurse signed the Narcan log for the entire 24 hour period.

APPENDIX B – PATIENT INTERVIEWS

The intent of this portion of the audit is to elicit substantive responses from the patient population, by utilizing each question as a springboard for discussion, with appropriate follow up to identify any areas where barriers to health care access may potentially exist. This is accomplished via interview of all the Americans with Disability Act (ADA) patients housed at the facility, the Inmate Advisory Council (IAC) executive body, and a random sample of patients housed in general population (GP). The results of the interviews conducted at (GSMCCF) are summarized in the table below.

Please note while this section is not rated, audit team members made every attempt to determine with surety whether any claim of a negative nature could be supported by material data or observation. The results are briefly discussed in the "comments" section below.

Patient Interviews (not rated)
Are you aware of the sick call process?
Do you know how to obtain a CDCR Form 7362 or sick call form?
Do you know how and where to submit a completed sick call form?
Is assistance available if you have difficulty completing the sick call form?
Are you aware of the health care grievance process?
Do you know how to obtain a CDCR Form 602-HC, *Health Care Grievance*?
Do you know how and where to submit a completed health care grievance form?
Is assistance available if you have difficulty completing the health care grievance form?
Questions 9 through 21 are only applicable to ADA patients.
Are you aware of your current disability/Disability Placement Program (DPP) status?
Are you receiving any type of accommodation based on your disability? (Like housing accommodation, medical appliance, etc.)
Are you aware of the process to request reasonable accommodation?
Do you know where to obtain a reasonable accommodation request form?
Did you receive reasonable accommodation in a timely manner?
Have you used the medical appliance repair program? If yes, how long did the repair take?
Were you provided interim accommodation until repair was completed?
Are you aware of the grievance/appeal process for a disability related issue?
Can you explain where to find help if you need assistance for obtaining or completing a form, (i.e., CDCR Form 602-HC, *Health Care Grievance*, CDCR Form 1824, Reasonable Modification or Accommodation Request, or similar forms)?
Have you submitted an ADA grievance/appeal? If yes, how long did the process take?
Do you know who your ADA coordinator is?
Do you have access to licensed health care staff to address any issues regarding your disability?
During the contact with medical staff, do they explain things to you in a way you understand and take time to answer any question you may have?

Comments:

The auditor interviewed ten patients; three IAC members and seven DDP designated patients. One patient spoke Spanish as his primary language and the facility provided an interpreter to assist with the interview. Five patients were hearing impaired and utilized hearing aids and vests identifying them as hearing impaired, but none of the patients arrived for the interview wearing their vest. The patients interviewed from the DDP list were not aware of who at the facility was designated as the ADA coordinator.

This information was presented to the facility's HSA while onsite, who assured she'd follow up these patients and provide them the necessary information. None of the DDP patients reported any difficulties with access to care at the facility or receiving health services related to their disabilities.

The IAC members reported the overall health care provided to the patient population was good. There was high praise for the medical care available and its quality. There were no stated issues for medication delivery and administration. There was concern raised about patients refusing appropriate medical care at the hub institution, owing to the continued perception of unnecessarily long stays interfering with the programing they receive at GSMCCF. The physician auditor discussed this concern with the PCP and he confirmed there are frequent refusals of important medical studies due to this very concern. The physician auditor tasked the PCP and nursing staff with tracking patients sent to the hub so they can follow-up on patient status in a timely manner.

All ten patients interviewed during the onsite audit expressed satisfaction with the health care services provided to them.

APPENDIX C – BACKGROUND AND AUDIT METHODOLOGY

1. BACKGROUND AND PROCESS CHANGES

In April of 2001, inmates, represented by the Prison Law Office, filed a class-action lawsuit, known as *Plata vs. Schwarzenegger*, alleging their constitutional rights had been violated as a result of the CDCR health care system's inability to properly care for and treat inmates within its custody. In June of 2002, the parties entered into an agreement (Stipulation for Injunctive Relief) and CDCR agreed to implement comprehensive new health care policies and procedures at all institutions over the course of several years.

In October 2005 the Federal Court declared that California's health care delivery system was "broken beyond repair," and continued to violate inmates' constitutional rights. Thus, the court imposed a receivership to raise the delivery of health care in the prisons to a constitutionally adequate level. The court ordered the Receiver to manage CDCR's delivery of health care and restructure the existing day-to-day operations in order to develop a sustainable system that provides constitutionally adequate health care to inmates.

In accordance with the Receiver's directive, the CCHCS Field Operations and Private Prison Compliance and Monitoring Unit's (PPCMU) management plan on conducting two rounds of audits in a calendar year for the private facilities Modified Community Correctional Facilities (MCCF) and the California out-of-state correctional facilities (COCF) currently in contract with CDCR. During the first six months of the calendar year, the PPCMU audit team will conduct an annual audit on all the facilities using the revised *Private Prison Compliance and Health Care Monitoring Audit Instruction Guide* (Revised November 2017) and Audit Tools. Based upon the overall audit rating received by the MCCF facility in their initial audit (*inadequate* or *adequate*), the facility will undergo a second round audit, which would be either a Full or a Limited Review. The COCF facilities will undergo two rounds of audits (full review or Limited Review) per calendar year regardless of the score received during the initial audit.

2. OBJECTIVES, SCOPE, AND METHODOLOGY

The *Private Prison Compliance and Health Care Monitoring Audit Instruction Guide* was developed by CCHCS in an effort to evaluate the effectiveness, efficiency, and compliance of the health care processes implemented at each contracted facility to facilitate patient access to health care. This audit instrument is intended to measure facility's compliance with various elements of patient access to health care, and also to identify areas of concern, if any, to be addressed by the facility.

The standards being audited within the *Private Prison Compliance and Health Care Monitoring Audit Instruction Guide* are based upon relevant Department policies and court mandates, including, but not limited to, the following: *IMSP&P*, *California Code of Regulations*, Title 8 and Title 15; *Department Operations Manual*; court decisions and remedial plans in the *Plata* and *Armstrong* cases, and other relevant Department policies, guidelines, and standards or practices which the CCHCS has independently determined to be of value to health care delivery.

The audit incorporates both *quantitative* and *qualitative* reviews.

Quantitative Review

The *quantitative* review uses a standardized audit instrument, measuring compliance against established standards at each facility. The audit instrument calculates an overall percentage score for each of the chapters in the *Administrative* and *Medical Component* sections as well as individual ratings for each component of the audit instrument.

To maintain a metric-oriented monitoring program that evaluates medical care delivery consistently at each correctional facility, CCHCS identified 12 medical and three administrative components of health care to measure. The *Medical* components cover clinical categories directly relating to the health care provided to patients, whereas the *Administrative* components address the organizational functions that support a health care delivery system.

The 12 medical program components are: *Access to Care, Diagnostic Services, Emergency Services and Community Hospital Discharge, Initial Health Assessment/Health Care Transfer, Medical/Medication Management, Observation Cells, Specialty Services, Preventive Services, Emergency Medical Response/Drills and Equipment, Clinical Environment, Quality of Nursing Performance* and *Quality of Provider Performance.* The three administrative components are: *Administrative Operations, Internal Monitoring and Quality Management and Licensing/Certifications, Training and Staffing.*

Every question within the chapter for each program component is calculated as follows:

- Possible Score = the sum of all Yes and No answers
- Score Achieved = the sum of all Yes answers
- Compliance Score (Percentage) = Score Achieved/Possible Score

The compliance score for each question is expressed as a percentage rounded to the nearest tenth. For example, a question scored 13 'Yes', 3 'N/A', and 4 'No".

Compliance Score = 13 'Yes' / 17 (13 'Yes' + 4 'No') = .764 x 100 = 76.47 rounded up to 76.5%.

The component scores are calculated by taking the average of all the compliance scores for all applicable questions within that component. The outcome is expressed as a percentage rounded to the nearest tenth. The qualitative rating for each component is described as *proficient*, *adequate*, or *inadequate* according to whether standards were met more than 90%, more than 80% or less than 80%. See Table below for the breakdown of percentages and its respective quality ratings.

Percentile Score	Associated Rating
90.0% and above	Proficient
80.0% to 89.9%	Adequate
Less than 80.0%	Inadequate

Ratings for clinical case reviews in each applicable component and overall will be described similarly.

Qualitative Review

The *qualitative* portion of the audit consists of case reviews conducted by clinical auditors. The clinical auditors include physicians and registered nurses. The clinicians complete clinical case reviews in order

to evaluate the quality and timeliness of care provided by the clinicians at the facilities. Individual patient cases are selected and followed utilizing an individual case review similar to well established methods utilized by the Joint Commission on Accreditation of Healthcare. Typically, individuals selected for the case review are those who have received multiple or complex services or have been identified with poorly controlled chronic conditions.

The cases are analyzed for documentation related to access to care, specialty care services, diagnostic services, medication management and urgent or emergent encounters. Once the required documentation is located in the record, the clinicians review the documentation to ensure that the abovementioned services were provided to the patients in accordance with the standards and scope of practice and the IMSP&P guidelines and to ensure complete and current documentation.

The clinical case reviews are comprised of the following components:

1. *Nurse Case Review*

   The NCPR auditors perform two types of case reviews:

   a. Detailed reviews – A retrospective review of ten selected patient health records is completed in order to evaluate the quality and timeliness of care provided by the facility's nursing staff during the audit review period.
   b. Focused reviews – Five cases are selected from the audit review period, three cases consist of patients who were transferred into the facility and two cases consist of patients transferred out of the facility with pending medical, mental health, or dental appointments. The cases are reviewed for appropriateness of initial nurse health screening, referral, timeliness of provider evaluations, continuity of care, and completeness of the transfer forms.

2. *Physician Case Review*

   The physician auditor completes a detailed retrospective review of 15 patient health records in order to evaluate the quality and timeliness of care provided to the patient population housed at that facility.

Overall Component Rating

The overall component rating is determined by reviewing the scores obtained from clinical case reviews and quantitative reviews. Scores for all components in the quantitative review are expressed as percentages. The clinical case review ratings are likewise reported in terms of the percentage of encounters that were rated as appropriate within the cases reviewed for each medical component. The final outcome for each component is expressed as a percentage and is calculated by averaging the quantitative and clinical case review scores received for that component.

For those components, where compliance is evaluated utilizing only one type of review (either clinical case or quantitative review), the overall component score will equate to the score attained in that specific review. For all those chapters under the *Medical Component* section, where compliance is evaluated utilizing both quantitative and clinical case reviews, **double weight** will be assigned to the results from the clinical case reviews, as it directly relates to the health care provided to patients. For example, in Component 4, *Access to Care*, Facility A received 85.5% for clinical case review and 89.5% for quantitative

review. The overall component score will be calculated as follows (85.5+85.5+89.5)/3 = 86.8%, equating to quality rating of *adequate*. *Note the double weight assigned to the case review score.*

Based on the derived percentage score, each quality component will be rated as either *proficient*, *adequate*, *inadequate*, or *not applicable*.

Overall Audit Rating

The overall rating for the audit is calculated by taking the percentage scores for all components (under both *Administrative* and *Medical* components) and dividing by the total number of applicable components.

$$\text{Overall Audit Rating} = \frac{\textit{Sum of All Points Scored on Each Component}}{\textit{Total Number of Applicable Components}}$$

The resultant percentage value is rounded to the nearest tenth and compared to the threshold value range (listed in Table below). The final overall rating for the audit is reported as *proficient, adequate, or inadequate* based on where the average percentage value falls among the threshold value ranges.

Average Threshold Value Range	Rating
90.0% - 100.0%	Proficient
80.0% - 89.9%	Adequate
0.0% to 79.9%	Inadequate

The compliance scores and ratings for each component are reported in the *Executive Summary table* of the final audit report.

Scoring for Non-Applicable Questions and Double-Failures:

Questions that do not apply to the facility are noted as Not Applicable (N/A). For the purpose of component compliance calculations, N/A questions will have zero (0) points available. Where a single deviation from policy would result in multiple question failures (i.e., "double-failure"), the question most closely identifying the primary policy deviation will be scored zero (0) points, and any resultant failing questions will be noted as N/A.

Resolution of Critical Issues

Although the facility will not be required to submit a corrective action plan to the Private Prison Compliance and Monitoring Unit for review, the facility will be required to address and resolve all standards rated by the audit that have fallen below the 80.0% compliance or as otherwise specified in the methodology. The facility will also be expected to address and resolve any critical deficiencies identified during the clinical case reviews and any deficiencies identified via the observations/inspections conducted during the onsite audit.