January 7, 2019

Minga Wofford, Warden
Jamie Pair, Health Services Administrator
McFarland Female Community Re-Entry Facility
120 Taylor Avenue
McFarland, CA 93250

Dear Warden Wofford and Ms. Pair,

The staff from California Correctional Health Care Services (CCHCS) conducted an onsite Private Prison Compliance and Health Care Monitoring re-audit at McFarland Female Community Reentry Facility (MFCRF), McFarland, from November 6 through 8, 2018. The purpose of this audit was to examine the facility's progress in resolving inadequate components and critical issues identified during the June 2018 annual audit.

On December 28, 2018, a draft report was provided to allow you the opportunity to review and dispute any findings presented in the report. On January 4, 2019, you submitted a response accepting the findings.

Attached is the final re-audit report in which MFCRF received an overall audit rating of *Inadequate* with a compliance score of 67.5%. This compliance score is a decrease of 9.5 percentage points from the prior June 2018 annual audit score of 77.0%. The scope of the re-audit included a re-examination of 13 components and 22 critical issues. The report contains an Executive Summary, list of critical issues, findings detailed by component, prior critical issue resolution, and an explanation of the methodology behind the audit.

As a result of this re-audit, two components received proficient scores, one received a passing score, and remaining ten components did not achieve a compliance threshold of 80.0%. The facility resolved 10 of the 22 previous critical issues and 18 new critical issues were identified during the re-audit. Most of the deficiencies identified during the past and current re-audit were mainly related to facility's provider and health care staff lacking knowledge of CCHCS health care standards and treatment protocols, and inadequate training.

Should you have any questions or concerns, please contact Anastasia Bartle, Staff Services Manager II (SSM II), Private Prison Compliance Monitoring Unit (PPCMU), Field Operations, Corrections Services at (916) 691-4921 or via the email at Anastasia.Bartle@cdcr.ca.gov.

Sincerely,

Joseph (Jason) Williams, Director (A)
Corrections Services
California Correctional Health Care Services

Enclosure

cc: 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
Steven Cox, Chief Deputy Administrator, Female Offender Program Services (FOPS), CDCR
Dionne Hudnall, Correctional Administrator, FOPS, 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
Zacarias Rubal, Captain, CBU, DAI, CDCR
Joseph K. Edwards, Captain, HCPOP and PPCMU, Field Operations, Corrections Services, CCHCS
Marcus Harris, Regional Health Services Manager, The GEO Group, Inc.
Philip Mallory, Chief Executive Officer (A), Central California Women's Facility, CDCR
Anastasia Bartle, SSM II, PPCMU, Field Operations, Corrections Services, CCHCS
Christopher Troughton, Health Program Manager I (A), PPCMU, Field Operations, Corrections Services, CCHCS

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

PRIVATE PRISON COMPLIANCE AND HEALTH CARE MONITORING AUDIT

McFarland Female Community Reentry Facility

Re-Audit

November 6 – 8, 2018

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DATE OF REPORT

January 7, 2019

INTRODUCTION

As a result of an increasing patient population and a limited capacity to house patients, the California Department of Corrections and Rehabilitation (CDCR) entered into contractual agreements with private prison vendors to house California patients. Although these patients 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 McFarland Female Correctional Re-entry Facility (MFCRF) on June 5 through 7, 2018. The audit review period was December 1, 2017 through March 31, 2018. The patient population at the time of the June onsite audit was 277 and the facility's budgeted capacity was 300[1]. The facility received an overall compliance rating of *Inadequate* (77.0%) based on the scores compiled from each of the 14 components. Seven components received a rating of *Inadequate*, and 22 critical issues were identified. As a result of the inadequate overall compliance rating, a complete re-audit was scheduled approximately six months after the annual audit.

The PPCMU audit team conducted a re-audit at MFCRF between November 6 through 8, 2018. The audit review period was June through September 2018. The patient population at the time of the onsite audit was 268 and the facility's budgeted capacity was 293[2].

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

[2] Data from CDCR's Weekly Population Count report, dated November 2, 2018.

The audit team consisted of the following personnel:

B. Barnett, Medical Doctor, Retired Annuitant
L. Pareja, Nurse Consultant, Program Review (NCPR)
K. Srinivasan, Health Program Specialist (HPS)
S. Carroll, HPS

The scope of the re-audit included a re-examination of all components except Preventive Services since this component is evaluated only once per calendar year during the annual audit. As a result of the November re-audit, the audit team found no improvement. The facility received an overall compliance rating of *Inadequate* (67.5%), a decrease of 9.5 percentage points from the score received during the annual audit. A comparison of the component scores between the June and November 2018 audits is listed below.

Executive Summary

Component	Audit Type	Clinical Case Review		Clinical Case Review	Quantitative Review	Overall Component
		Nurse	Provider			
1. Administrative Operations	A	N/A	N/A	N/A	77.7%	77.7% *Inadequate*
	RA	N/A	N/A	N/A	92.5%	92.5% *Proficient*
	+/-				+14.8	+14.8
2. Internal Monitoring and Quality Management	A	N/A	N/A	N/A	76.2%	76.2% *Inadequate*
	RA	N/A	N/A	N/A	75.1%	75.1% *Inadequate*
	+/-				-1.1	-1.1
3. Licensing/ Certifications, Training, and Staffing	A	N/A	N/A	N/A	80.0%	80.0% *Adequate*
	RA	N/A	N/A	N/A	50.0%	50.0% *Inadequate*
	+/-				-30.0	-30.0
4. Access to Care	A	88.7%	87.5%	88.1%	87.8%	88.0% *Adequate*
	R	73.5%	66.7%	70.1%	92.4%	77.5% *Inadequate*
	+/-	-15.2	-20.8	-18.0	+4.6	-10.5
5. Diagnostic Services	A	76.2%	40.0%	58.1%	87.5%	67.9% *Inadequate*
	RA	75.0%	33.3%	54.2%	90.5%	66.3% *Inadequate*
	+/-	-1.2	-6.7	-3.9	+3.0	-1.6

6. Emergency Services and Community Hospital Discharge	A	88.9%	40.0%	64.4%	N/A[3]	64.4% *Inadequate*
	RA	25.0%	50.0%	37.5%	33.3%	36.1% *Inadequate*
	+/-	-63.9	+10.0	-26.9		-28.3
7. Initial Health Assessment/Health Care Transfer	A	90.5%	83.3%	86.9%	94.4%	89.4% *Adequate*
	RA	79.2%	80.0%	79.6%	64.3%	74.5% *Inadequate*
	+/-	-11.3	-3.3	-7.3	-30.1	-14.9
8. Medical/ Medication Management	A	80.2%	35.0%	57.6%	91.9%	69.0% *Inadequate*
	RA	78.8%	16.7%	47.7%	81.0%	58.8% *Inadequate*
	+/-	-1.4	-18.3	-9.9	-10.9	-10.2
9. Observation Cells (COCF Only)		N/A	N/A	N/A	N/A	N/A
10. Specialty Services	A	68.4%	100.0%	84.2%	80.0%	82.8% *Adequate*
	RA	68.8%	0.0%	34.4%	58.1%	42.3% *Inadequate*
	+/-	+0.4	-100.0	-49.8	-21.9	-40.5
11. Preventive Services	A	N/A	N/A	N/A	92.3%	92.3% *Proficient*
	RA	N/A	N/A	N/A	N/A[4]	N/A
	+/-					
12. Emergency Medical Response/Drills & Equipment	A	N/A	N/A	N/A	57.5%	57.5% *Inadequate*
	RA	N/A	N/A	N/A	85.0%	85.0% *Adequate*
	+/-				+27.5	+27.5
13. Clinical Environment	A	N/A	N/A	N/A	93.3%	93.3% *Proficient*
	RA	N/A	N/A	N/A	98.8%	98.8% *Proficient*
	+/-				+5.5	+5.5

[3] This component section could not be reviewed. Auditors were unable to establish an adequate sample size.

[4] This component is audited once per year.

14. Quality of Nursing Performance	A	83.5%	N/A	83.5%	N/A	83.5% *Adequate*
	RA	74.8%	N/A	74.8%	N/A	74.8% *Inadequate*
	+/-	-8.7		-3.2		-8.7
15. Quality of Provider Performance	A	N/A	55.8%	55.8%	N/A	55.8% *Inadequate*
	R	N/A	45.7%	45.7%	N/A	45.7% *Inadequate*
	+/-		-10.1	-10.1		-10.1

Overall Audit Score and Rating	**Annual**	**77.0%** ***Inadequate***
	Re-Audit	**67.5%** ***Inadequate***
	+/-	**-9.5**

Refer to Appendix A for results of the quantitative review, Appendix B for results of the patient interviews conducted at MFCRF, and Appendix C for additional information regarding the methodology utilized to determine the facility's compliance for each requirement and overall audit score and rating.

IDENTIFICATION OF CRITICAL ISSUES

The table below reflects all quantitative analysis standards the facility's compliance fell below acceptable compliance levels. The table also includes any *qualitative* critical issues or concerns identified by the audit team rising to the level having the potential to adversely affect patients' access to health care services. During the annual audit, 22 critical issues were identified. During the re-audit, auditors found 10 of the 22 critical issues resolved, 12 unresolved, and 18 new. As a result, a total of 30 critical issues were identified and are listed below.

Critical Issues – McFarland Female Community Reentry Facility	
Question 1.2	The facility's policies/local operating procedures are not all in compliance with the *Inmate Medical Services Policies and Procedures.* ***This is an unresolved critical issue since the June 2018 audit.***
Question 2.2	The facility's Quality Management Committee's (QMC) review process does not consistently include documented corrective action plan for the identified opportunities for improvement. ***This is a new critical issue.***
Question 2.4	The facility does not submit all the weekly and monthly monitoring logs within the specified time frames. ***This is an unresolved critical issue since the June 2018 audit.***
Question 2.5	The facility does not accurately document all data on the Sick Call Monitoring Log. ***This is an unresolved critical issue since the June 2018 audit.***
Question 2.6	The facility does not consistently document all data on the Specialty Care Monitoring Log. ***This is an unresolved critical issue since the June 2018 audit.***
Question 2.7	The facility does not accurately document all data on the Hospital Stay/Emergency Department/Hub Emergency Services 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 2.13	The facility does not consistently process institutional level health care grievances in the specified time frame. ***This is an unresolved critical issue since the June 2018 audit.***
Question 3.3	The facility does not provide the required training to its health care staff. ***This is an unresolved critical issue since the June 2018 audit.***
Question 3.4	The facility does not have a centralized system for tracking all health care staff licenses and certifications. ***This is a new critical issue.***
Question 3.6	The facility did not complete the peer review for the primary care provider (PCP) within the specified time frame. ***This is a new critical issue.***
Question 4.5	The facility's Registered Nurses (RNs) do not consistently document Effective Communication (EC) was established and education was provided to patients. ***This is a new critical issue.***
Question 4.8	The facility's care team does not adequately document the daily care team huddle. ***This is an unresolved critical issue since the May 2017 audit.***
Question 6.1	The facility's nursing staff does not review the discharge plans/instructions upon patient's return. ***This is a new critical issue.***

Question 6.4	The prescribed medications are not administered/delivered to the patient as ordered by the PCP. ***This is a new critical issue.***
Question 7.4	The facility does not complete a patient's scheduled or pending medical, dental or mental health appointment within the time frame specified by the sending facility's provider. ***This is a new critical issue.***
Question 7.7	The facility's nursing staff do not consistently document all of the patient's pending appointments on a CDCR Form 7371, *Health Care Transfer Information Form*. ***This is a new critical issue.***
Question 7.8	Not all of facility's nursing staff know what documents are required to be placed into the Transfer Envelope. ***This is an unresolved critical issue since the June 2018 audit.***
Question 8.1	Patients are not consistently receiving their chronic care medications within the required time frame. ***This is an unresolved critical issue since the June 2016 audit***.
Question 8.4	The facility does not consistently administer the anti-tuberculosis (TB) medication(s) to the patient as prescribed by the provider. ***This is a new critical issue.***
Question 8.5	The facility does not consistently monitor the patient monthly while the patient is on anti-TB medications. ***This is a new critical issue.***
Question 8.6	The facility's PCP does not consistently document the patient was provided education on the newly prescribed medication(s). ***This is a new critical issue.***
Question 8.12	The facility's nursing staff are not all knowledgeable of the Medication Error Reporting procedure. ***This is a new critical issue.***
Question 10.2	The facility's RNs do not consistently complete a face-to face assessment of the patient upon their return from the specialty services appointment and prior to returning to their housing unit. ***This is a new critical issue.***
Question 10.3	The facility's RNs do not consistently notify the PCP of any immediate medication or follow-up requirements provided by the specialty consultant upon the patient's return from a specialty services appointment. ***This is a new critical issue.***
Question 10.4	The facility's PCP does not consistently review the specialty consultant's report/discharge summary and complete a follow-up appointment with the patient within the required time frame. ***This is an unresolved critical issue since the May 2017 audit.***
Question 11.3	The facility does not consistently offer colorectal screening to patients between 50 and 75 years of age. ***This is an unresolved critical issue since the May 2017 audit.***
Question 12.4	The facility staff does not consistently submit all required documents to the Emergency Medical Response Review Committee (EMRRC) for their review. ***This is an unresolved critical issue since the June 2016 audit.***
Question 12.6	The facility does not resupply and reseal the Emergency Medical Response (EMR) bag before the end of the shift the bag was opened following an EMR drill. ***This is a new critical issue.***

NOTE: A discussion of the facility's progress toward resolution of all critical issues identified during *previous* health care monitoring audit is included in the *Prior Critical Issue Resolution* portion of this report.

AUDIT FINDINGS – DETAILED BY COMPONENT

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 health records and related information, as well as maintaining compliance with all Health Insurance Portability and Accountability Act requirements.

Case Review Score: *Not Applicable*
Quantitative Review Score: *92.5%*

Overall Score: 92.5%

The compliance for this component is evaluated by auditors through the review of patient health 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.

McFarland Female Community Reentry Facility received a compliance score of 92.5% (*Proficient*) with one previously identified critical issue resolved and the other unresolved. This is an increase of 14.8 percentage points from the June 2018 annual audit score of 77.7% (*Inadequate*). Eight questions were rated in this component; seven questions scored proficient, and one inadequate.

Quantitative Review Results

During the June 2018 annual audit, the facility submitted LOPs to account for 11 out of the 15 required program areas. The four missing areas were *Aerosol Transmissible Diseases Exposure Control Plan*, *Diagnostic Services, Maintenance/Management of Patient Medical Records and Release of Medical Information,* and *Narcan Use and Storage.* In addition, auditors found four topics were non-compliant with IMSP&P resulting in seven compliant topics out of 15, or 46.7% compliance. The four non-compliant LOP topics were *Initial Health Screening/Health Care Transfer Process; Health Care Staff Licensure and Training; Infection Control; and Tuberculosis Surveillance Program Procedure.*

During the re-audit, the facility submitted LOPs for 14 out of the 15 required areas. Auditors found an LOP was again not submitted for *Maintenance/Management of Patient Medical Records and Release of Medical Information,* and eight program areas were not compliant with IMSP&P, resulting in six compliant areas out of 15 for a score of 40.0% compliance. This is a decrease of 6.7 percentage points from previous audit score. This critical issue remains unresolved. The non-compliant LOP topics are discussed below:

1. ***Access to Care (Sick Call):*** The facility's LOP *Scheduling and Access to Care Procedure* (GEO Group Inc. Policy # 603-B (Effective Date: October 2017) was found compliant during the June 2018 annual audit. During the re-audit, the auditor found the LOP had been revised (Effective Date: September 2018) and was no longer compliant. The LOP does not discuss the following:
    - Daily Care Huddle procedures
    - The time frame for the PCP to see a patient following registered nurse (RN) referral.

- The procedures to be followed by nursing staff when a patient is unable to complete a CDCR Form 7362, *Health Care Services Request*.

(References: IMSP&P, Volume 1, Chapter 8, *Implementation and Review of Health Care Policies and Procedures;* Volume 4, Chapter 1.2, *Care Teams and Patient Panels Procedure*, Volume 4, Chapter 1.3, *Scheduling and Access to Care Procedure.)*

2. ***Aerosol Transmissible Diseases (ATD) Exposure Control Plan***: The facility did not submit an LOP during the June 2018 annual audit. During the re-audit, an LOP was submitted, *Aerosol Transmissible Diseases Exposure Control* (GEO Group Inc. Policy # 515-C, effective date October 2017). The LOP is missing the following sections:
   - Referring Units
   - Engineering and Work Practice Controls and Personal Protective Equipment
   - Respiratory Protection
   - Medical Services
   - Training
   - Recordkeeping
   - Staff responsibilities
   - The facility did not provide documentation showing the LOP is reviewed annually.

   (References: IMSP&P, Volume 1, Chapter 8, *Implementation and Review of Health Care Policies and Procedures*; Volume 1, Chapter 27, *Aerosol Transmissible Disease Exposure Control Plan Policy LOP Template*).

3. ***Diagnostic Services:*** During the June 2018 annual audit, the facility did not submit an LOP for this program area. During the re-audit, an LOP was submitted, *Diagnostic Services* (GEO Group, Inc. Policy # 1003, effective date of May 16, 2016). The LOP was determined to be non-compliant due to the following reasons:
   - It does not specify the details of the facility's process for providing diagnostic services to patients; it only states the facility will provide a range of necessary diagnostic services onsite or offsite as needed.
   - Does not state specific time frames for completion of diagnostic tests based on order priority.
   - Does not state the specific time frames for PCP's review of test results.
   - Does not state specific time frame for providing written notification of test results to the patient following their receipt and review.
   - The facility did not provide documentation showing the LOP is reviewed annually.

   (References: IMSP&P, Volume 1, Chapter 8, *Implementation and Review of Health Care Policies and Procedures*; Volume 4, Chapter 1.8, *Laboratory Services Procedures*)

4. ***Durable Medical Equipment (DME) and Medical Supplies:*** During the re-audit, the facility submitted a new LOP, *Durable Medical Equipment and Medical Supply* (GEO Group Inc. Policy # 1004, effective date September 2018). The LOP does not state the PCP is to complete a CDCR 7221-DME, *Physician's Orders for Durable Medical Equipment/Medical Supplies* if a need for DME is identified. Instead, the LOP states PCP will complete a Health Care Services Physician's Request for Services. (Reference: IMSP&P, Volume 1, Chapter 8, *Implementation and Review of Health*

Care Policies and Procedures; Volume 4, Chapter 32, *Durable Medical Equipment and Medical Supply Procedure*)

5. ***Emergency Medical Response and Drills***: During the June 2018 annual audit, the LOP *Emergency Medical Response and Drills* (GEO Group, Inc. Policy # 608-B, effective date of January 2017) was found compliant. During the re-audit, the auditor found the LOP had been revised (Effective Date: September 2018) and was no longer compliant. The LOP does not discuss or state:
    - The frequency of the EMRRC meetings.
    - The EMRRC meeting minutes shall be signed by the warden or their designee and the health services administrator.
    - The procedures to be followed by EMRRC for timely review of emergency medical responses or drills.
    - The procedures for inventory or resupplying and resealing of the EMR bags.
    - The facility PCP's responsibilities upon a patient's return to the facility from the hub or following a community hospital discharge.
    - Process for regular maintenance of EMR equipment and supplies, and
    - Completion of the CDCR Form 7463, *First Medical Responder Data Collection Tool*, during emergency medical responses and/or drills.

    (References: IMSP&P, Volume 1, Chapter 8, *Implementation and Review of Health Care Policies and Procedures*; Volume 4, Chapter 12.2: *Emergency Medical Response System Procedure*; Volume 4, Chapter 12.6: *Emergency Medical Response Bag Audit/Checklist Procedure*; Volume 4, Chapter 12.8, *Emergency Medical Response: Post Event Procedure*)

6. ***Health Appraisal, Initial Health Screening/Health Care Transfer Proce*ss**: During the June 2018 annual audit, the facility submitted two LOPs for this program area. The first LOP, *Physicals and Health Assessments* (Geo Group, Inc. Policy # 601-B), is missing the requirement for the facility's nursing staff to complete the CDCR Form 7277, *Initial Health Screening (All Institutions)* and CDCR Form 7227-A, *Initial Health Screening (Supplemental) – Female Inmates* at the time of a patient's initial health screening. The second LOP, *Medical Transfers* (GEO Group Inc. Policy # 211-B), does not state the steps to be completed by the RN during patient transfers. During the re-audit, auditors found neither deficiency was addressed. (References IMSP&P, Volume 1, Chapter 8, *Implementation and Review of Health Care Policies and Procedures*; Volume 4, Chapter 3.2, *Health Care Transfer Procedure*)

7. ***Specialty Care Services:*** During the June 2018 annual audit, the facility submitted the LOP Off-Site Hospital and Specialty Care (Geo Group, Inc. Policy 211-B). At the time, no deficiencies were identified in the LOP. During the current full audit, the facility did not submit an LOP for this program area. Therefore, the facility is non-compliant. (References: IMSP&P, Volume 1, Chapter 8, *Implementation and Review of Health Care Policies and Procedures*; Volume 4, Chapter 8, *Outpatient - Specialty Services*).

8. ***Tuberculosis Surveillance Program Procedure:*** During the June 2018 annual audit, the facility submitted the LOP *Tuberculosis Prevention and Management, Inmates* (Geo Group, Inc. Policy #528-B, effective January 2017. It was found non-compliant because it was not specific to the facility processes at MFCRF. During the re-audit, the facility submitted the same document but with an effective date of July 2018. The NCPR auditor determined it non-compliant because the LOP does not discuss:

- The facility's procedure for annual TB screening.
- The facility's procedure for symptoms screening or TB testing (if indicated) during the patient's initial intake at the facility.
- The designated nursing staff who should conduct screening based on a patient's TB status.
- The reporting mechanisms for newly identified patients with TB.

(References: IMSP&P, Volume 1, Chapter 8, *Implementation and Review of Health Care Policies and Procedures*; Vol 10, Chapter 3.2 *Tuberculosis Surveillance Program Procedure; CCHCS Care Guide: Tuberculosis- Surveillance*)

Three of the facility's LOPs identified as non-compliant during the previous annual audit were determined to be compliant during the re-audit:

1. ***Health Care Staff Licensure and Training***: During the June 2018 annual audit, the facility submitted the LOP *Staff Licensure and Training* (Geo Group, Inc. Policy #406-B, effective date March 2018) omitting specific time frames for completing PCP peer reviews and the frequency for the re-credentialing process. During the re-audit, the auditor found the revised LOP (effective date September 2018) compliant.
2. ***Infection Control and Blood Borne Pathogen:*** During the June 2018 annual audit, the facility did not provide documentation showing an annual review was completed for the facility's LOP *Infection Control Program* (Geo Group, Inc. Policy #515-B). During the re-audit, the revised LOP (effective date September 2018) was found compliant.
3. ***Narcan Use and Storage****:* During the June 2018 annual audit, the facility did not provide an LOP. During the re-audit, the facility submitted the LOP, *Naloxone Emergency Medical Response Procedure* (GEO Group Inc. Policy # 608-C, effective date June 20, 2018) and was found compliant.

While reviewing the LOPs provided by MFCRF during the re-audit, the auditors discovered additional deficiencies. These deficiencies are not included in the scope of this re-audit and are not part of the scoring for this question. The findings are described below.

- ***Staff Licensing and Training***: The HPS auditor's review of the facility's LOP (#406-B) showed the LOP does not mention the various classifications of health care staff employed at the facility (such as LVN, RN, PCP, etc.) and does not state training will be provided to the health care staff on IMSP&P and CCHCS care protocols.
- ***Americans with Disabilities Act***: The facility's LOP *Americans with Disability Act (ADA) & Durable Medical Equipment and Supply (DME)* (GEO Group, Inc. Policy # 901-B, effective date January 2017) is missing the following information:
  - While describing the ADA requirements, the LOP incorrectly refers to the CDCR Form 7536 as the Comprehensive Accommodation Chrono. The correct form is CDCR Form 7410, *Comprehensive Accommodation Chrono*. The CDCR Form 7536 is the *Durable Medical Equipment and Medical Supply Receipt* wherein the patient is required to sign acknowledging they received DME.
  - The LOP does not state the patients may request reasonable accommodation by filling out a CDCR Form 1824, *Reasonable Accommodation Request*.
  - When citing the requirements for DME within this policy, the LOP inaccurately states the patient is financially responsible for damage, repair, and replacement of appliances and parts. Per IMSP&P, "*Patients shall not be financially responsible for the cost to purchase*

medically necessary DME. The patient shall not be financially responsible for necessary repair, and replacement of DME and parts resulting from non-destructive treatment of this item. All patients shall be financially responsible for damage caused by personal neglect, misuse, or intentional destruction."

- ***Medication Management***: The facility's LOP *Pharmacy Services* (Geo Group, Inc. Policy # 715-B, effective date October 2017) does not include the following information:
  - The procedures for administration of nurse administered (NA) medications,
  - monitoring of patients on anti-TB medications,
  - medication availability procedures,
  - PCP responsibility to provide education to patients on newly prescribed medications, and
  - procedures for storage of drugs and vaccines

  (References: IMSP&P, Volume 1, Chapter 8*, Implementation and Review of Health Care Policies and Procedures;* Volume 4, Chapter 11.4*, Medication Administration Procedure;* Volume 4, Chapter 11.2*, Medication Orders, Prescribing Procedure;* Volume 9, Chapter 12*, Labeling and Storage of Medications Procedure).*

CCHCS notifications of IMSP&P revisions are emailed to all contracted facilities upon release. Between July and November 2018, the facility's HSA acknowledged receipt of 11 out of the 21 updates provided. The auditors recommend the facility create a timely process for submitting acknowledgments and creating policy addendums, as needed, until the annual review date of the affected policy.

During the June 2018 annual audit, the facility's Inmate Orientation Handbook did not accurately describe the process for submitting and processing health care grievances (Question 1.4). This critical issue is unresolved since the November 2017 audit. The re-audit revealed the handbook was updated to reflect the September 2017 adoption of health care grievance regulations. This critical issue is resolved.

During the onsite audit, auditors discovered the facility's health care staff do not have internet access to the IMSP&P. Due to the facility's network firewall settings, the CCHCS internet site was inadvertently blocked. This issue was discussed with the facility's CDCR Captain who agreed to work with the facility's Information Technology staff to facilitate internet access to IMSP&P.

2. INTERNAL MONITORING & QUALITY MANAGEMENT

Case Review Score: *Not Applicable*
Quantitative Review Score: *75.1%*

Overall Score: 75.1%

This component focuses on whether the facility completes internal reviews and holds committee meetings in compliance with the CCHCS policies. Auditors review the minutes from Quality Management Committee (QMC) meetings to determine if the facility identifies opportunities for improvement; implements action plans to address the identified deficiencies; and continuously monitors the quality of health care provided to patients. Auditors 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 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

McFarland Female Community Reentry Facility received a compliance score of 75.1% (*Inadequate)* with two of the six previously identified critical issues resolved and four new critical issues identified. This is a decrease of 1.1 percentage points from the June 2018 annual audit score of 76.2% (*Inadequate*). Thirteen questions were rated in this component; five questions scored proficient, and eight inadequate.

Upon review of the various monitoring logs received by PPCMU, the auditor found MFCRF did not consistently submit them timely (Question 2.4). During the audit review period, 40 of the 59 required submissions were submitted timely. See table below for additional information. This critical issue remains unresolved.

Type of Monitoring Log	Required Frequency of Submission	Number of Required Submissions for the Audit Review Period	Number of Timely Submissions	Number of Late Submissions
Sick Call	weekly	17	12	5
Specialty Care	weekly	17	12	5
Hospital Stay/Emergency Dept	weekly	17	12	5
Chronic Care	monthly	4	2	2
Initial Intake Screening	monthly	4	2	2
	Totals:	**59**	**40**	**19**

During the June 2018 annual audit, the Sick Call Monitoring Log was deemed non-compliant due to erroneous entries resulting in 76.5% compliance (Question 2.5). During the re-audit, auditors found erroneous PCP appointment dates resulting in a score of 64.7% compliance. During the annual audit, the Specialty Care Monitoring Log was also found non-compliant, resulting in 71.4% compliance (Question 2.6). During the re-audit, the facility was found non-compliant due to missing documentation associated with the log entry, resulting in 60.0% compliance. Both critical issues remain unresolved.

Additionally, during the re-audit, auditors found the other three monitoring logs were inaccurate resulting in three new critical issues. The facility's Hospital Stay/Emergency Department/Hub Emergency Services Monitoring Log scored 50.0% compliance (Question 2.7), the Chronic Care Monitoring Log scored 58.8% compliance (Question 2.8), and the Health Screening Monitoring Log scored 75.0% compliance (Question 2.9). Missing documentation in the Electronic Health Record System (EHRS) to substantiate the data reported on the monitoring logs was the primary reason for non-compliance. The auditors discussed this issue with the HSA and the Medical Records Clerk and recommended the Medical Records Clerk implement an internal quality control process to check and verify the health records sent to CCWF are scanned timely into the EHRS. This could be accomplished by spot checking the EHRS at least twice a week for scanned copies of 40 to 50 percent of the records sent, and documenting the findings on a log. This information could then be shared with the health records staff at CCWF in an effort to identify and resolve barriers. The Medical Records Clerk agreed to implement this recommendation.

During the June 2018 annual audit, the facility did not have CDCR Forms 602-HC-A *Health Care Grievance Attachment* in housing unit "D", resulting in 75.0% compliance (Question 2.10). During the re-audit,

auditors observed a sufficient supply of both the CDCR Form 602 HC *Health Care Grievance* and CDCR 602-A readily available in all four housing units, resulting in 100% compliance. This critical issue is resolved.

During the June 2018 annual audit, auditors found the facility's health care grievance tracking log did not contain the required fields resulting in 0.0% compliance (Question 2.12). Health care staff were not processing grievances within the required time frame resulting in 14.3% compliance (Question 2.13).

On July 13, 2018, PPCMU provided all facilities an Institutional Grievance Log for their use during the 2018/19 Fiscal Year. This log is based on an Excel worksheet with dropdown menus and automatically calculates the grievance due date based on the receipt date entered. In addition to the log, the facilities received the grievance regulations and Health Care Grievance Operating Standards initially distributed in September 2017 during a webinar.

During the re-audit, auditors found the facility's tracking log contained all the required fields to capture information per the California Code of Regulations, Title 15, Article 8.6, *Health Care Grievances*, resulting in 100% compliance for Question 2.12, but found health care staff were still not processing grievances timely resulting in 50.0% compliance for Question 2.13. Of note, one grievance was assigned two months after it was received by health care staff. This critical issue remains unresolved.

While reviewing the seven health care grievances submitted during the audit review period, auditors noted the following:

- Six grievances were missing the date of receipt and triage,
- three "completed" grievances were missing the disposition,
- three distinct grievances submitted by one patient were addressed in one written response,
- three grievances were addressed by the PCP educating the patient on the grieved medical issue in lieu of a written response, and
- one written response provided to the patient was missing the HSA's signature.

The week of October 22, 2018, the CCHCS' Health Care Correspondence and Appeals Branch (HCCAB) rolled out CCHCS's Health Care Appeals and Risk Tracking System 2.0 (HCARTS 2.0) to the in-state contracted facilities replacing the Excel based log. On October 25, 2018, the MFCRF HSA received six hours of onsite training on the health care grievance operating standards and use of HCARTS 2.0 to track and process institutional level health care grievances. During the re-audit, auditors noted the HSA had access to HCARTS 2.0 and was utilizing this system to track and process grievances.

3. LICENSING/CERTIFICATIONS, TRAINING & STAFFING

This component determines whether the facility adequately manages its health care staffing resources by evaluating whether: job performance reviews are completed as required; professional licenses and certifications are current; and training requirements are met. The auditors also determine whether clinical and custody staff are current with their emergency medical response certifications and if the facility is meeting staffing requirements specified in the contract.

Case Review Score:
Not Applicable
Quantitative Review Score: *50.0%*

Overall Score: 50.0%

This component is evaluated by the auditors through the review of the facility's documentation of health care staff licenses, medical emergency response certifications, health care staff training records, and staffing information. 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

McFarland Female Community Reentry Facility achieved an overall compliance score of 50.0% (*Inadequate*) with three critical issues identified. This is a significant decrease of 30 percentage points from the June 2018 annual audit score of 80.0% (*Adequate*). Six questions were reviewed; three were rated proficient and three were rated inadequate.

During the June 2018 annual audit, the facility did not utilize a tracking log to track training provided to health care staff resulting in 0.0% compliance (Question 3.3). During the re-audit, the facility did not submit a tracking log and stated they don't utilize one. During the onsite audit, the facility's HSA submitted copies of staff training binders to the auditors with a list of trainings provided to the staff including training hours and dates of completion. A review of these training binders showed the staff did not receive annual training and the training documentation was incomplete due to missing dates. The facility also did not provide any documentation showing the health care staff received training on the facility's LOPs or revised IMSP&P.

During the re-audit, two new critical issues were identified. The HSA was unsure of the facility's process for tracking health care staff licenses, certifications, and was unsure of the person responsible for tracking this information, resulting in 0.0% compliance for Question 3.4. Second, the facility did not submit the PCP's peer review to PPCMU by the due date, August 16, 2018, resulting in 0.0% compliance for Question 3.6.

4. ACCESS TO CARE

This component evaluates the facility's ability to provide the 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.

Case Review Score: *70.1%*
Quantitative Review Score: *92.4%*

Overall Score: 77.5%

The facility received an overall compliance score of 77.5% (*Inadequate*). This is a decrease of 10.5 percentage points from the June 2018 annual audit score of 88.0% *(Adequate)*. Specific findings related to the nurse and physician case reviews and the electronic health record reviews are documented below.

Case Review Results

The facility received an overall case review compliance score of 70.1% for this component. The current score is a decrease of 18 percentage points from the June 2018 score of 88.1%. The clinical auditors reviewed a combined total of 58 encounters related to *Access to Care*.

Nurse Case Reviews

The NCPR auditor reviewed 49 nursing encounters and identified 13 deficiencies, resulting in 73.5% compliance. This is a decrease of 15.2 percentage points from the June 2018 score of 88.7%.

- **In Case 16**, four deficiencies were identified in this case. Initially, when the patient was seen by the RN on July 27, 2018, for complaint of right thumb pain, the RN did not document EC was established with the patient. The patient was seen a second time on August 15, 2018, for the patient's request for x-ray due to persistent pain in the right thumb. The RN did not conduct an objective and subjective assessment, and did not document EC was established during the encounter. The patient submitted a CDCR Form 7362 on August 20, 2018, documenting her refusal to go to medical if she had to go to the hub institution, Central California Women's Facility (CCWF), to receive treatment for her thumb injury. The patient also requested a mammogram on the CDCR Form 7362. The patient was seen by the RN on the same day of the request. However, the RN did not conduct an objective and subjective assessment related to the patient's injured thumb or address patient's refusal to go to the hub. Additionally, for the third time, the RN did not document EC was established with the patient. The patient was seen on September 9, 2018, for the same complaint of pain in the right thumb. Once again, the RN took the patient's vital signs and did not conduct an adequate objective assessment. The RN should have assessed the patient's right thumb.
- **In Case 18**, the patient submitted a CDCR Form 7362 complaining she was "feeling bad" and wanted to go for mental health evaluation; however, the patient refused to be seen by the RN. A CDCR Form 7225, *Refusal of Examination and/or Treatment,* was completed and signed by the patient, but there was no documentation showing the RN established EC with the patient.
- **In Case 19**, three deficiencies were identified. When the patient refused to see the RN for complaints of diarrhea and stomach cramping, a CDCR Form 7225 was completed but the RN did not specify what the patient refused on the form. For another encounter on September 5, 2018, a CDCR Form 7225 was completed showing the patient had refused a treatment. However, nursing staff did not document the specific treatment being refused. The third deficiency is related to the patient's annual Tuberculosis (TB) evaluation not completed in her birth month. A reason was not documented in the patient's health record explaining why the TB evaluation was not completed at the specified time frame.
- **In Case 20**, the PCP ordered weekly blood pressure (BP) monitoring for the patient. However, there was no documentation in the patient's health record showing the PCP's order was implemented.
- **In Case 21**, the RN completed a nursing assessment for hemorrhoids per nursing protocol. However, a CDCR Form 7362 could not be located in the patient's health record related to patient's complaint of hemorrhoids. If the patient was unable to complete a CDCR Form 7362, the nursing staff should have completed one on patient's behalf.

- **In Case 23,** when the patient refused a follow-up for mental health evaluation offered due to the presence of an elevated risk of PREA[5], the refusal was not documented on a CDCR Form 7225.
- **In Case 24,** two deficiencies were identified. The first deficiency is related to the patient's annual TB evaluation not conducted in the patient's birth month and the second deficiency is related to the nursing staff not completing an adequate objective assessment of the patient for complaint of rashes on her arms and legs possibly due to consuming mac and cheese the previous night. A skin assessment should have been conducted as a part of the objective assessment. Instead, the nursing staff only took the vital signs of the patient.

Physician Case Reviews

The physician auditor reviewed nine provider encounters and identified three deficiencies, resulting in 66.7% compliance. This is a decrease of 20.8 percentage points from the June 2018 score of 87.5%.

- **In Case 7,** the morbidly obese pre-diabetic patient with history of hypertension, metabolic syndrome, and hyperlipidemia is scheduled for a follow up appointment on September 4, 2018, 90 days after initial appointment with the PCP. The physician auditor determined this was too long an interval for a follow up appointment due to patient's high risk of frank diabetes and complications associated with this condition. The patient refused the follow up appointment, but the PCP did not take any action upon notification of the patient's refusal. The follow up care provided by the PCP was determined to be inadequate given the patient's poor health condition.
- **In Case 9,** the patient was seen by nursing staff on September 1, 2018 for back pain. The nurse's progress note indicated the patient was referred to the PCP for further evaluation. However, the physician auditor could not find documentation showing the PCP examined the patient. Due to the patient's diabetic condition, the patient was at risk for spine infection or other significant illness associated with back pain such as kidney disease, aneurysm, etc. Lack of exam by the PCP suggests PCP's failure to be in communication with the nursing staff regarding patient appointments and follow-ups. The physician auditor determined the PCP either failed to document his assessments of patients or the PCP was not diligently following up with patients as required.
- **In Case 10,** the patient complained of blood in stool on July 31, 2018. There was no documentation of a work up by the PCP to find the cause of this alarming complaint. The PCP ordered birth control pills (BCP) for vaginal spotting; however, there was no documentation of a pelvic exam to rule out cervical and uterine pathology, or a Pap smear, and no lab test was ordered for complete blood count (CBC) to rule out anemia. Patient's obesity also increased risk of endometrial cancer. The physician auditor determined the care provided was below community standard due to the PCP's tendency to treat patients before considering causes of abnormal uterine bleeding such as polycystic ovarian syndrome, adenomyosis[6], leiomyoma[7], malignancy, coagulopathy[8], ovulatory dysfunction, etc. and lack of attention given to patient's complaint of blood in stool. Pregnancy test must be done in all such patients of reproductive age. The auditor noted although OB/GYN consultation was available it was not accessed.

[5] PREA: The Prison Rape Elimination Act, 2003. Provides for the analysis of the incidence and effects of prison rape and to provide information, resources, recommendations, and funding to protect individuals from prison rape.

[6] Adenomyosis: Condition in which the inner lining of the uterus breaks through the muscle wall of the uterus (the myometrium).

[7] Leiomyoma: Also called uterine fibroids; noncancerous growths of the uterus that often appear during childbearing years.

[8] Coagulopathy: Also called a bleeding disorder; a condition in which the blood's ability to coagulate (form clots) is impaired.

Quantitative Review Results

McFarland Female Community Reentry Facility attained a quantitative score of 92.4% (*Proficient*) with two critical issue identified. This is an increase of 4.6 percentage points from the June 2018 annual audit score of 87.8% (*Adequate*). Ten questions were reviewed; seven were proficient, one adequate, and two were inadequate.

During the re-audit, NCPR auditor reviewed 16 patient electronic health records, and 12 had documentation showing EC was established by health care staff, resulting in 75.0% compliance for Question 4.5. This is a decrease of 25 percentage points from the 100.0% scored during the June 2018 annual audit, and a new critical issue. The NCPR auditor discussed this issue with the HSA and the Regional Manager of Health Care Services, GEO Group, Inc. Although IMSP&P only requires documentation of EC for patients with TABE Score of 4 or less, the standard of nursing practice requires establishment of EC for any treatment rendered or while discussing treatment plans with the patient. As a reminder, the NCPR auditor recommended the HSA ensure all health care staff document EC was established or place the EC stamp on all nursing protocol forms and/or interdisciplinary progress notes. In cases where nursing staff choose to document treatment plans on CDCR Form 7362, EC should be documented on the form.

During the annual audit, the facility did not adequately document their Daily Care Team Huddles and the facility scored 0.0% compliance (Question 4.8). During the re-audit, the NCPR auditor reviewed the Daily Care Team Huddle documentation for 19 business days and documentation for 14 days was determined to be adequate, resulting in 73.7% compliance. The facility did not submit Daily Huddle documentation for September 19, 2018. For the remaining four days, there was inadequate documentation of actions taken for issues identified, such as patients new to the care team admitted within the previous week did not have appointments to be seen (Item number 5); for patients who left care team within the past seven days, there was no documentation of any handoff to the new care team (Item number 6); for patients with appointments on the day of the huddle, there was no documentation the necessary documents were available for the appointment, and there was no documentation of identified issues needing to be addressed during the patient's appointment. This critical issue remains unresolved.

During the entrance conference, the facility's HSA stated the Daily Care Team Huddle is held daily at 11 a.m. The auditors expressed concern regarding the late schedule and recommended the huddle take place before the clinic hours. The auditors also informed the facility the Daily Care Team Huddle agenda items should include a list of patients to be seen that day, patients who require higher level of care or those returning from higher level of care, significant diagnostic test results, and these items are to be discussed before the clinic activity commences. The audit team recommended the care team meet at 8:00 a.m. daily to plan and coordinate patient care activities and clinical operations for the day's work with the goal of preventing lapses in patient care and improving patient outcomes. The facility's management agreed to implement the audit team's recommendation.

During the onsite audit, an RN stated there were several patient refusals for sick call appointments because a number of patients call in sick in order to skip the facility's daily programs/activities. Since all patients are required to submit a CDCR Form 7362 to be seen for their health care problems, these patients complete a CDCR Form 7362, but refuse to be seen at the time of the appointment because their complaints are not legitimate. The NCPR auditor recommended the RN discuss this issue with custody to minimize this practice in order to prevent misuse of facility's health care resources. The NCPR also

discussed with nursing staff the facility's failure to use the correct patient refusal form, CDCR Form 7225, to document patient refusals of medical services. The auditor recommended consistent use of CDCR Form 7225 for documenting all patient refusals.

The physician auditor observed the PCP and nursing staff did not work as a team and there seemed to be a lack of understanding on how to establish teamwork. There was no evidence of any collaboration between the PCP and the facility RNs. For example, a patient requesting to see the physician during a nurse sick call should be accommodated and seen briefly by the physician when possible.

5. DIAGNOSTIC SERVICES

For this component, the clinical auditors assess several types of diagnostic services such as radiology, laboratory, and pathology. The auditors review the patient health records to determine whether radiology and laboratory services were provided timely, whether the PCP completed a timely review of the results, and whether the results were communicated to the patient within the required time frame. Information regarding the appropriateness, accuracy and quality of the diagnostic tests ordered, and the clinical response to the results is evaluated via the case review process.

Case Review Score: 54.2%
Quantitative Review Score: *90.5%*

Overall Score: 66.3%

The facility received an overall compliance score of 66.3% (*Inadequate*). This is a decrease of 1.6 percentage points from the June 2018 score of 67.9%.

Case Review Results

The facility received an overall case review compliance score of 54.2% (*Inadequate*). The current score is a decrease of 3.9 percentage points from the June 2018 case review score of 58.1%. The clinician auditors reviewed a combined total 14 encounters for this component.

Nurse Case Reviews

The NCPR auditor reviewed eight nursing encounters and identified two deficiencies resulting in a score of 75.0% compliance. This is a decrease of 1.2 percentage points from the June 2018 score of 76.2%.

- **In Case 21,** the PCP ordered a Complete Blood Count (CBC) with differential count, Hepatic Function Panel and PT/INR[9] tests for the patient; however, there was no documentation in the patient's health record showing these tests were completed as ordered.
- **In Case 25,** the PCP ordered labs for the patient, namely, CBC with differential count, complete metabolic panel (CMP), Hemoglobin A1c[10], lipid panel, urine analysis and RPR[11] tests on June 14, 2018. Documentation in the patient's health record shows a blood sample was collected on September 9, 2018, for lipid panel and CMP tests; however, the sample was collected past the

[9] A prothrombin time (PT) is a test used to help detect and diagnose a bleeding disorder or excessive clotting disorder.
[10] A hemoglobin A1c (HbA1c) test measures the amount of blood sugar (glucose) attached to hemoglobin.
[11] A rapid plasma reagin (RPR) test is a blood test used to screen for syphilis.

required time frame of 14 days (for routine lab tests) from the ordered date. There was no documentation in the health record to indicate if the remaining labs were completed.

Physician Case Reviews

The physician auditor reviewed six provider encounters and identified four deficiencies, resulting in a compliance score of 33.3%. This a decrease of 6.7 percentage points from the June 2018 score of 40.0%.

- **In Case 3,** two deficiencies were identified. First, the patient was assessed on July 13, 2018, for abdominal complaints based on urine analysis results showing less than 50,000 colonies and report of "fishy" vaginal discharge. The PCP's diagnosis of urinary tract infection (UTI) was probably in error due to a relatively low bacterial count of streptococcus, which is an atypical pathogen for UTI, and patient's spurious symptoms. The PCP failed to obtain a wet smear to validate diagnosis of bacterial or trichomonas vaginitis. Per the PCP's documentation in the progress note on July 24, the PCP once again failed to validate the diagnosis of UTI, and the patient was ordered to continue the same medication. The patient also requested a lower bunk which was denied by the PCP. The PCP should have investigated the relatively healthy 24 year old patient's request for a lower bunk along with presentation of specious symptoms which might suggest malingering, and possible need for psychiatric evaluation and/or services.
- **In Case 8,** the patient was scheduled for a follow up appointment for lab results on June 4, 2018. The lab test was ordered in June, but completed only towards the end of August. So, the test was not done on time and no follow up was ordered for 90 days. The physician auditor determined the PCP made a provisional diagnosis of macrocytic anemia and ordered folate, but did not test the patient for B12 deficiency and also did not consider other possible causes for patient's anemia. Lab tests on August 31, 2018, showed life threatening anemia. But the PCP did not document action was taken to address this abnormal finding. The auditor also noted the PCP did not appear to access the patient's health records in the e-UHR to review past history, lab tests, and progress notes completed by other providers.
- **In Case 11,** the PCP ordered an X-ray for the patient's injured thumb on August 28, 2018. However, the PCP did not document the X-ray findings and did not follow up with the patient. The patient refused the appointment with the PCP the following week on September 5, 2018. The physician auditor determined the PCP should have had the X-ray within a day or two, and a follow up should have been completed before the end of the week.

Quantitative Review Results

McFarland Female Community Reentry Facility received a quantitative compliance score of 90.5% (*Proficient*), an increase of 3.0 percentage points from the June 2018 score of 87.5%. Of the four questions rated, two were proficient and two inadequate.

During the annual audit, diagnostic tests were not completed for eight patients within the time frame specified by the PCP, resulting in 66.7% compliance (Question 5.2). During the re-audit, 14 of the 15 records reviewed showed the diagnostic test was completed within the time frame specified, resulting in 93.3% compliance. The critical issue is resolved. No new critical issues were identified.

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: *37.5%*
Quantitative Review Score: *33.3%*

Overall Score: 36.1%

The auditors evaluate the emergency medical response system and the facility's ability to provide effective and timely emergency medical responses, assessment, treatment and transportation 24 hours per day. 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.

The facility received an overall score of 36.1% (*Inadequate*). This is a decrease of 28.3 percentage points from the June 2018 score of 64.4%.

Case Review Results

The facility received an overall case review score of 37.5%. This is a decrease of 26.9 percentage points from the June 2018 case review score of 64.4%. The auditors reviewed a combined total of six encounters for this component.

Nurse Case Reviews

The NCPR auditor reviewed four encounters and identified three deficiencies, resulting in a score of 25.0%. This is a decrease of 63.9 percentage points from the June 2018 score of 88.9%.

- **In Case 20**, when the patient returned to the facility from the hub following an Emergency Room (ER) visit on August 16, 2018, the nursing staff did not document the review of the patient's discharge instructions or summary. Additionally, the nursing staff did not countersign on the CDCR Form 7371, *Health Care Transfer Information,* received from the hub to indicate the receiving nurse reviewed the patient's information.
- **In Case 23,** two deficiencies were identified. The first deficiency is related to a sick call visit on August 31, 2018. The patient was seen by nursing staff for complaints of right side upper chest pain. But the nursing staff did not conduct an adequate objective assessment of the patient such as appearance of anxiety or fright, diaphoresis, pallor, difficulty in breathing, neck vein distention, etc. The nursing staff also did not follow the chest pain protocol such as administering oxygen, aspirin, etc. to the patient. This patient suffered a stroke in 2010. The nursing staff referred the patient to PCP but the disposition was "routine" and the appointment was scheduled to occur five days later, on September 5, 2018. When the patient presented with abnormal vital signs (pulse rate=37, respiratory rate=16 and BP=140/83) along with complaint of chest pain, the RN's disposition should have been "emergent" and not "routine." More importantly, the RN should have notified the PCP STAT and not five days later. The second deficiency was related to the nursing staff not documenting a nursing assessment prior to the patient's transfer to the community hospital ER on September 5, 2018. Although the patient was assessed by the PCP

prior to transfer, the nursing staff should have documented an assessment of the patient or completed the required forms during an emergency service. This patient was later admitted at San Joaquin Community Hospital with diagnosis of ventricular bigeminy and bradycardia.

Physician Case Reviews

The physician auditor reviewed two encounters and identified one deficiency resulting in a score of 50.0%. This is an increase of 10.0 percentage points from the June 2018 score of 40.0%.

- **In case 8,** the patient's lab results showed severe, possibly life threatening anemia. However, there was no follow up by the PCP on the low hematocrit value of 23, possibly could be due to gastro-intestinal bleed or life threatening anemia from other causes.

Quantitative Review Results

McFarland Female Community Reentry Facility received a quantitative compliance score of 33.3% (*Inadequate*) with two critical issues identified. Question 6.3 could not be evaluated due to the unavailability of a valid sample. Of the four questions rated, one was proficient and two inadequate.

During the June 2018 annual audit, quantitative reviews were not completed for this component due to unavailability of valid samples meeting the criteria. During the re-audit, the NCPR auditor reviewed the electronic health record of one patient who returned to MFCRF from the hub institution following a community hospital discharge. There was no documentation in the health record showing the patient's discharge plan or instructions were reviewed by the RN, resulting in 0.0% compliance (Question 6.1). In addition, this patient did not receive the prescribed medications lisinopril, carvedilol and hydroeucerin, per policy or as ordered by the provider, resulting in 0.0% compliance (Question 6.4). Non-urgent new medication orders received by the pharmacy on any business day must be available to the patient no later than four business days unless otherwise ordered.

7. INITIAL HEALTH ASSESSMENT/HEALTH CARE TRANSFER

Case Review Score: *79.6%*
Quantitative Review Score: *64.3%*

Overall Score: 74.5%

This component determines whether the facility adequately manages patient 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 providing pre-existing health conditions, pending medical, dental and mental health appointments, medication transfer packages, and medication administration prior to transfer.

The facility received an overall score of 74.5% (*Inadequate*). This is a decrease of 14.9 percentage points from the June 2018 score of 89.4%.

Case Review Results

The facility received an overall case review score of 79.6%. This is a decrease of 7.3 percentage points from an adequate score of 86.9% achieved during the June 2018 annual audit. The auditors reviewed a combined total of 29 encounters for this component.

Nurse Case Reviews

The NCPR auditor reviewed 24 encounters and identified five deficiencies, resulting in 79.2% compliance. This is a decrease of 11.3 percentage points from the June 2018 score of 90.5%. All five deficiencies were related to the nursing staff not completing the required transfer forms prior to the patient's transfer to another facility and for completing a CDCR Form 7371, *Health Care Transfer Information* days, before the patient's transfer to another facility.

- **In Case 16**, the patient was referred to the orthopedic clinic at the hub. The nursing staff completed a face-to-face assessment of the patient prior to her transfer. However, the NCPR auditor could not locate a CDCR Form 7371 completed by nursing staff in the patient's electronic health record.
- **In Case 18**, the patient was scheduled to be transferred to the hub. The nursing staff completed a face to face assessment of the patient prior to transfer. However, the NCPR auditor could not locate a CDCR Form 7371 completed by nursing staff in the patient's electronic health record.
- **In Case 19**, the patient was transferred to the hub on September 18, 2018. However, the NCPR auditor found a CDCR Form 7371 was completed on September 10, 2018, a week before the date of actual transfer. Additionally, the patient had a pending Request for Services (RFS) for excision of submandibular mass, however this was not noted on the CDCR Form 7371.
- **In Case 20**, nursing staff completed the PREA Screening form, but the PREA intake screening questions were not completed.
- **In Case 22,** the patient was transferred to California Institute for Women, but the NCPR auditor did not find the required transfer documents in the patient's electronic health record.

Physician Case Reviews

The physician auditor reviewed four encounters and identified one deficiency, resulting in 80.0% compliance. This is a decrease of 3.3 percentage points from the June 2018 score of 83.3%.

- **In Case 6,** the patient had a complete history and physical exam and appropriate lab tests were ordered. However, diagnosis of Carpal Tunnel Syndrome (CTS) was made with dubious evidence (pain in three fingers). The physician auditor found the PCP's examination of the patient's extremities to be deficient. No motor function or sensory exam was conducted. The patient did not have a history of night pain. Although diagnosis might be correct, the documentation was inadequate. The physician auditor identified a knowledge gap in proper diagnosis of CTS. The treatment and follow up were inadequate. The PCP should have followed up to ensure if patient did have CTS, the treatment was effective rather than leading onto permanent deficits.

Quantitative Review Results

McFarland Female Community Reentry Facility received a quantitative compliance score of 64.3% (*Inadequate*) with three critical issues identified. This is a decrease of 30.1 percentage points from the

prior audit score of 94.4%. Question 7.3 could not be evaluated due to the unavailability of a valid sample. Of the seven questions rated, two were proficient, two adequate, and three inadequate.

During the re-audit, the NCPR auditor reviewed 12 health records of patients who arrived at the facility during the review period. Only one patient had a pending gynecology consult for August 17, 2018. The auditor did not find any documentation in the patient's health record showing this appointment was completed as scheduled, resulting in 0.0% compliance (Question 7.4). The NCPR auditor also reviewed 12 records of patients transferring out of the facility during the audit review period and identified six patients with pending appointments at the time of transfer, only three patient records had pending appointments listed on a CDCR Form 7371 (Question 7.7). The three non-compliant records did not contain a completed CDCR form 7371. This resulted in 50.0% compliance.

During the June 2018 annual audit, the NCPR auditor observed the facility's transfer out process and found the CDCR Form 7371, *Health Care Transfer Information,* in one of the transfer envelopes was incomplete, resulting in a compliance score of 66.7% (Question 7.8). During the re-audit, there were no patients scheduled to be transferred out of the facility. Therefore, the NCPR auditor interviewed three facility RNs regarding the transfer process and found only one was knowledgeable about the process, resulting in a score of 33.3%. This issue remains unresolved.

The NCPR auditor observed during patient transfers, nursing staff do not consistently document face-to-face evaluation of patients prior to offsite appointments and upon their return to the facility. The NCPR auditor explained the importance of documenting patient's baseline condition prior to transferring the patient offsite and upon their return to the facility. The NCPR auditor recommended the HSA prepare Transfer Envelopes containing all documents as required by IMSP&P and train nursing staff on preparing this packet.

8. MEDICAL/MEDICATION MANAGEMENT

Case Review Score: *47.7%*
Quantitative Review Score: *81.0%*

Overall Score: 58.8%

For this component, the clinical auditors assess the facility's health care staff performance to determine whether appropriate and medically necessary care was provided to patient population that is in line with the nursing and physician scope of practices and clinical guidelines established by the department. This includes, but is not limited to the following: proper diagnosis, appropriateness of medical/nursing action, and timeliness and efficiency of treatments and care provided related to the patient's medical complaint. The clinical auditors also assess the facility's process for medication management which includes: timely filling of prescriptions, appropriate dispensing of medications, appropriate medication administration, completeness in documentation of medications administered to patients, and appropriate maintenance of medication administration records. This component also factors in the appropriate storing and maintenance of refrigerated drugs, vaccines, and narcotic medications.

The facility received an overall score of 58.8% (*Inadequate*). This is a decrease of 10.2 percentage points from the June 2018 audit score of 69.0%.

Case Review Results

The facility received an overall case review score of 47.7% (*Inadequate*). This is a decrease of 9.9 percentage points from 57.6% compliance achieved during the June 2018 annual audit. The auditors reviewed a combined total of 98 encounters for this component.

Nurse Case Reviews

The NCPR auditor reviewed 80 encounters and identified 17 deficiencies, resulting in a score of 78.8% compliance. This is a decrease of 1.4 percentage points from the June 2018 score of 80.2%.

- **In Case 16**, a total of six deficiencies were identified. The PCP ordered a 30-day supply of hydroeucerin ointment on June 4, 2018, for topical application b.i.d (twice a day). However, there was no MAR documentation in the patient's health record showing the patient received the medication within four business days. All non-urgent medication orders received by the pharmacy on any business day must be received by the patient within four business days. The patient received amlodipine 30 tablets as KOP on June 11, 2018. However, the RN who administered the medication did not initial the MAR. In addition, there was no record of previous date of administration for this medication; hence the NCPR auditor could not determine if the patient received this medication timely. On June 13, the patient received clotrimazole cream and 25 milligrams (mg) hydrochlorothiazide (HCTZ), and the RN and the patient signed the MAR indicating receipt of medications. However, the NCPR auditor could not find a record of previous date of administration for both these medications because the patient's signature was missing on the MAR for May 2018. Hence, the auditor could not determine if the patient received the medications timely. The PCP prescribed a 90-day supply of Norvasc (amlodipine) 5 mg and 30-day supply of calcium carbonate for the patient on August 3, 2018. The patient should have received the amlodipine on August 5 because the previous supply was administered on July 6, 2018. However, the patient received the refill for amlodipine only on August 11, 2018. Similarly, the patient received her 30-day supply of HCTZ late on August 4, 2018. The previous supply of this medication was administered on June 13, 2018. All non-urgent renewed medication orders received by pharmacy on any business day needs to be refilled and received by the patient no less than one business day before the exhaustion of the 30-day supply. The same patient received dulcolax 5mg tab for constipation on August 8, 2018. The patient signed the MAR indicating receipt of the medication. However, the administering RN did not sign/initial the MAR. The MAR should be signed or initialed by both the administering nurse and the patient.
- **In Case 18,** the patient's MAR dated August 8, 2018, showed Eucerin cream was available for administration. The patient's signature was missing on the MAR to indicate receipt of this medication. Since the medication was available on August 8, it should have been received or refused by the patient on or before August 13, because the patient has only four business days to receive a Keep-on-Person (KOP) medication when it is available or sign a refusal form in case the medication is refused. However, the patient signed the refusal form late on August 14, 2018.
- **In Case 19,** two deficiencies were identified. The patient was prescribed amoxicillin on June 16, 2018, to be administered orally every eight hours for ten days. However, the documentation on the MAR showed the medication was administered to the patient only at 6:00 am and 2:00 pm on June 17, 2018, and not administered at 10:00 pm. On August 2, 2018, the PCP ordered Tylenol 325 mg, two tabs for seven days to be taken for pain every eight hours as

required. There was no documentation in the MAR indicating the patient received the Tylenol within the required time frame of four business days.

- **In Case 20,** two deficiencies were identified. The PCP ordered lisinopril, carvedilol, hydroeucerin, and benzoyl peroxide for the patient on August 16, 2018. The patient received the ordered medications late on August 23, 2018. New medication orders faxed to the pharmacy on any business day should be available to the patient within four business days. The patient also received a 30-day refill of lisinopril 40 mg late on September 30, 2018. The patient received the first order of 30-day supply of this medication on August 23, 2018. All non-urgent renewed medication orders received by pharmacy on any business day needs to be refilled and received by the patient no less than one business day before the exhaustion of the 30-day supply.
- **In Case 21,** three deficiencies were identified; two were related to patients receiving medications late and one was related to an RN not administering the medication to the patient as ordered. On August 7, 2018, the PCP ordered hydrocortisone cream for topical application t.i.d (thrice a day) for seven days, and Benadryl 25 mg 1 tab b.i.d (twice a day) for seven days to be taken as needed for itching. Both medications were not received timely by the patient. They should have been available to the patient within four business days from the time medication orders were faxed to the pharmacy on any given business day. The PCP ordered to discontinue Topamax 150mg for the patient, and prescribed to start the patient on 100 mg Topamax b.i.d for 90 days and Flonase for 90 days. The NCPR auditor was unable to find a directly observed therapy (DOT) MAR showing Topamax was given as ordered. Lastly, the documentation on the MAR posted on August 1, 2018, showed the patient received the third dose of twinrix was administered intramuscularly on August 6, 2018. However, there was no documentation showing when the first and second dose of twinrix were given. The NCPR auditor also could not locate a physician's order for this medication in the patient's electronic health record.
- **In Case 22,** the patient received 30-day supplies of both KOP medications simvastatin and calcium carbonate/Vitamin D late on June 27, 2018, since the previous supplies were received on May 9, 2018, per the documentation on the MAR. Non-urgent renewed medications should be received no less than one business day before the previous 30-day supply is exhausted.
- **In Case 24,** on August 6, 2018, the PCP ordered Notrel, one tab to be taken by mouth, six cycles, and Fiber Lax one tab orally t.i.d for 90 days. The patient received Fiber Lax late on August 16 and there was no MAR showing the patient received Notrel.
- **In Case 25,** on June 13, 2018**,** the PCP ordered xopenex HFA two puffs to be used every six hours as needed for shortness of breath and low-ogestrel tabs, to be taken one tab daily for 30 days. Low-ogestrel tabs were received by the patient on June 16. However, there was no MAR showing patient received xoponex HFA.

Physician Case Reviews

The physician auditor reviewed 18 provider encounters and identified 15 deficiencies resulting in 16.7% compliance. This is a decrease of 18.3 percentage points from the July 2018 score of 35.0%.

- **In Case 1**, four deficiencies were identified. The patient was seen for a chronic care follow-up on July 19 and 20, 2018, for asthma and herpes. The PCP's progress note indicated the patient used a rescue inhaler on a daily basis. The progress notes also described the patient's asthma was in "good control." However, the patient's daily use of inhaler indicated otherwise. The physician

auditor noted the PCP did not modify the treatment to address the patient's poor controlled asthma because the patient's daily use of rescue inhaler is a strong indication for adding a long term control agent such as corticosteroid inhaler. On June 27, 2018, the PCP also prescribed a 30 day supply of 400 mg ibuprofen in lieu of prescribing the medication as PRN[12] because neither the patient's exam nor history justified a 30-day supply. On September 4, 2018, the patient's prescription for hydrocell cream was renewed with no justification for the prescription. The physician auditor determined the PCP's practice of prescribing excessive medications lead to polypharmacy, and risk of NSAID[13] exceeded benefits in this case.

- **In Case 3**, four deficiencies were identified. The patient was seen on June 4, 2018, for history and physical exam, and the PCP assessed the patient for asthma. During this encounter, the PCP prescribed flagyl for the patient for complaint of vaginal discharge without conducting an exam. The physician auditor determined the PCP had no reason for failing to examine the patient and observe the discharge under a microscope to validate the diagnosis. Moreover, this practice was wasteful and also exposed the patient to dangerous side effects of the drug. This patient was examined by an RN for migraine on June 19, 2018, and the PCP prescribed 500 mg Naprosyn to be taken twice a day without conducting an exam. Again, the auditor did not find any reason for the PCP's failure to examine the patient and validate the RN's diagnosis. If the patient truly suffered from migraine, it indicates the need for exam and treatment by the PCP. The same patient was seen on June 29 for abdominal pain and PCP assessed the pain to be muscular in nature and patient's headaches as migraine without sufficient basis for these diagnoses. The PCP prescribed NSAIDS for the patient. The physician auditor identified the PCP as having an apparent knowledge gap in headache/migraine assessment. The diagnosis of abdominal pain as muscular was not validated by exam or history, and treatment with ibuprofen is inappropriate as drug is dangerous. On July 24, the patient was seen for a follow up and the patient is told to continue the same medications with no validation of diagnosis. The patient's request for a lower bunk was denied by the PCP. The continued request of the 24 year old patient for a lower bunk with suspicious symptoms suggests malingering, and possibly a need for psychiatric evaluation and services. The need for psychiatric care is evident from the patient's refusal of a subsequent visit to the PCP for a Pap smear. Psychiatric services may not be sufficiently available to assist PCP in assessing personality disorders or malingering.

- **In Case 4**, the patient is seen for a follow up and PCP orders Zithromax for patient's rash diagnosed as Pityriasis Rosea (PR)[14]. However, the physician auditor determined the authoritative medical literature reports Zithromax has no role in treatment of PR. The PCP did not appear to be using any of the computer or text book resources available to him, which would make clear PR is NOT to be treated with Zithromax.

- **In Case 7**, the PCP prescribed nitroglycerin and excessive anti hypertensives with no evidence in the medical record of heart disease needing those drugs. The physician auditor noted the PCP prescribes excessively without evidence in the record to justify. Follow-up care is unnecessarily delayed. No appointment to monitor weight, lab testing, or symptoms in record for 90 days.

- **In Case 8**, the PCP renewed the patient's prescription for 400 mg ibuprofen twice a day x 10 days for menstrual cramps without exam or establishing a diagnosis. The patient had been previously

[12] PRN: Abbreviation meaning "when necessary" (from the Latin "pro re nata").

[13] NSAID: Nonsteroidal anti-inflammatory drugs. E.g., Ibuprofen, aspirin, etc.

[14] Pityriasis Rosea: A relatively common skin condition that causes a temporary rash of raised, red scaly patches on the body.

diagnosed as being anemic, (per PCP's progress notes on June 4, 2018) and therefore PCP should not have prescribed NSAIDs in excessive amounts.

- **In Case 9**, three deficiencies were identified. The PCP ordered blood sugar test for the patient on June 19, 2018, following a finger stick , the patient had a reading of 249. However, there was no blood drawn. The physician auditor determined the follow up scheduled to occur in 30 days was too delayed given the patient's uncontrolled Diabetes Mellitus (DM). Patient refused the medication Januvia, but PCP did not refer patient to psychiatry for refusal of medication. The PCP did not appear to consider the patient should have been seen weekly to establish MD relationship. Poor diabetic control injures patient with long term adverse effects on kidneys, heart, and eyes. On August 13, 2018, patient's medication Tylenol 500 mg was renewed for 30 days. Patient was given two refills to treat headaches. However, a diagnosis was not documented on the PCP's progress note to justify long term and chronic treatment with Tylenol. The physician auditor determined the patient possibly suffered from analgesic headaches actually made worse by excessive use of Tylenol. Per the auditor, PCP has sufficient time to explore a diagnosis of headache and treat according to best practices due to low total patient load. Lastly, on August 28, 2018, the PCP prescribed Eucerin for patient's "dry skin" with no examination. The diabetic patient was already at risk for serious skin conditions, including infection with yeast and bacteria. The patient should have been examined by the PCP for skin complaints. Prescribing without good faith exam is contrary to medical principles and California law; relying upon nurse exam without training or supervision (despite application of protocol) may be tantamount to facilitation of medical practice without a license - also violation of California Medical Practice Act[15].
- **In Case 15**, the PCP ordered acetaminophen for putative headache without conducting an exam. The physician auditor expressed concern treatment without exam is disfavored and possibly violated medical practice act. The auditor noted PCP frequently ordered drugs on basis of nurse requests, with no exam, or even documenting if it was done later to justify his prescription.

Quantitative Review Results

McFarland Female Community Reentry Facility received a compliance score of 81.0% (*Adequate)* with five critical issues identified. Fourteen questions were reviewed; seven were rated proficient, five rated inadequate, and two were not rated due to unavailability of samples meeting the rating criteria.

During the June 2018 annual audit, the electronic health record reviews showed patients did not receive chronic care medications timely, resulting in 12.5% compliance (Question 8.1). During the current re-audit, the NCPR auditor's review of 16 patient health records showed six patients received their medications within the specified time frame, resulting in 37.5% compliance.

The NCPR auditor was unable to rate Questions 8.2 and 8.3 since there were no medication refusals documented during the review period.

During the re- audit, four new critical issues were identified. The NCPR auditor's review of five electronic health records showed the facility administered the prescribed anti-tuberculosis (TB) medications as prescribed to three patients resulting in 60.0% compliance (Question 8.4). The electronic health record

[15] Medical Practice Act – an act adopted by individual states to protect the public from unqualified doctors and fraudulent medical procedures specifically requires that physicians prescribe medications or treatments ONLY after a "good faith" examination. California Business and Professions Code 2242.

reviews also showed one out of two patients was monitored monthly while on anti-TB medications (Question 8.5), resulting in 50.0% compliance. The PCP provided education on newly prescribed medications to eight out of 12 patients reviewed, achieving 66.7% compliance (Question 8.6).

During the onsite audit, the NCPR auditor interviewed three nursing staff on medication error reporting procedure and found one RN was unable to describe the medication error reporting process, resulting in 66.7% compliance (Question 8.12). The RNs who were familiar with the process were knowledgeable of the old reporting process and not the current one, where medication errors required to be reported using the online Health Care Incident Reporting system. The NCPR auditor informed the facility regarding the new process in medication error reporting.

Several deficiencies related to timeliness of patient receipt of chronic care medication were identified during the annual audit and re-audit. Since the facility is not receiving medications from Central Fill Pharmacy (CFP), it currently does not have a tracking mechanism to determine if patients have sufficient supply of their routine chronic care medications prior to exhaustion of their 30-day supply, and this leads to patients not receiving their medications timely. Since the facility uses a third party pharmacy, Correct Rx, to procure medications for patients, GEO management informed the NCPR auditor regarding their plans to coordinate with Correct Rx pharmacy and to find an alternative solution to correct this deficiency. It is anticipated when CFP or hub pharmacy undertakes the responsibility to provide medication refills to MFCRF as planned, this issue will likely be resolved.

9. OBSERVATION CELLS (California Out of State Correctional Facilities (COCF) Only)

This component applies only to California out-of-state correctional facilities. The auditors examine whether the facility follows appropriate policies and procedures when admitting patients to onsite inpatient cells. All aspects of medical care related to patients housed in observations cells are assessed, including quality of provider and nursing care.

10. SPECIALTY SERVICES

In this component, clinician auditors determine whether patients are receiving approved specialty services timely, whether the provider reviews related specialty service reports timely and documents their follow-up action plan for the patient, and whether the results of the specialists' reports are communicated to the patients. For those patients who transferred from another facility, the auditors assess whether the approved or scheduled specialty service appointments are received and/or completed within the specified time frame.

Case Review Score: *34.4%*
Quantitative Review Score: *58.1%*

Overall Score: 42.3%

McFarland Female Community Reentry Facility received an overall compliance score of 42.3% (*Inadequate*), a decrease of 40.5 percentage points from the previous June 2018 score of 82.8%.

Case Review Results

The facility received an overall case review compliance score of 34.4% (*Inadequate*). This is a decrease of 49.8 percentage points from the previous June 2018 case review score of 84.2% (*Adequate*). The auditors reviewed a combined total of 22 encounters related to this component.

Nurse Case Reviews

The NCPR auditor reviewed 16 encounters and identified five deficiencies, resulting in a compliance score of 68.8%. This is an increase of 0.4 percentage points from the June 2018 score of 68.8%.

- **In Case 16**, two deficiencies were identified. The patient was scheduled for a specialty services appointment for an X-ray at Truxton radiology on September 5, 2018. The nursing staff did not conduct a face-to-face assessment of the patient prior to patient's transport to this appointment. When this patient returned from the offsite appointment the same day, the nursing staff documented a face-to-face assessment of the patient; however, nursing did not mention the specific specialty service the patient had received offsite.
- **In Case 17,** the PCP completed an RFS for an obstetrics gynecology (OB/GYN) consult on August 3, 2018. However, there was no available documentation in the patient's health record indicating the OB/GYN consult was completed as ordered. The documentation on the RFS stated "returned on 8/10/18, I/P due to be released 8/16/18, transferred 8/4/18." It was not clear to the auditor what these notes meant.
- **In Case 18,** two deficiencies were identified. The patient had an offsite specialty services appointment on September 5, 2018, but there was no documentation in the health record showing the nursing staff completed a face-to-face assessment of the patient prior to the patient's transport to the appointment. When this patient returned from the offsite appointment the same day, the nursing staff documented a face-to-face assessment of the patient; however, nursing did not mention the specific specialty service the patient had received offsite.

Physician Case Reviews

The physician reviewed six encounters and found all six encounters to be deficient, resulting in 0.0% compliance. This is a decrease of 100 percentage points from the June 2018 score of 100%.

- **In Case 4**, two deficiencies were identified. The patient was seen on July 23, 2018, for complaints of rashes. The PCP described the rash as "non-specific" in his progress note and did not make a diagnosis. Per the physician auditor, "non-specific" does not describe a rash sufficiently to diagnose. If PR is suspected in this age group at risk for syphilis, immediate testing should be done. The patient was again seen on August 3, 2018, for complaints of excessive vaginal bleeding. No labs were ordered, no pelvic exam was documented, and there was no documentation of consultation with a specialist. Complete blood count (CBC) was not ordered until the following week. The CBC showed anemia. The PCP should have completed an exam due to patient's history of fibroids. The PCP should have consulted by phone with colleagues at another women's prison for appropriate advice regarding bleeding and necessity for further studies before ordering BCP to control bleeding.

- **In Case 9**, the PCP did not order an HbA1c test although there was no change to the patient's weight. The patient's DM remains poorly controlled puts patient at substantial risk of adverse outcomes. The patient deserved nutritional counseling and mental health services.
- **In Case 11**, the patient was referred to surgery for excision of neck mass, possibly a cancer, with no follow up. Referral is made with priority as "routine" which might take 90 days for processing[16]. The patient was not referred to the hub for treatment of Hepatitis C virus (HCV). Additionally, the PCP treated the patient's vaginitis without an exam or a wet smear to validate the treatment.
- **In Case 12**, two deficiencies were identified. The patient was diagnosed with a breast mass on ultrasound in April 2018. The patient had a follow up appointment on June 22, 2018. But the PCP failed to refer the patient timely to surgery for breast mass although it was recommended for surgical evaluation/biopsy/excision at the time of diagnosis[17]. During a belated follow-up appointment for the breast mass on August 2, 2018, a mammogram was ordered, but there was no referral document found in the patient's health record. There was no documentation of follow up in the patient's record to indicate an urgent referral to surgery consultation/treatment. The follow up by PCP on this high risk patient was determined to be poor.

Quantitative Review Results

The facility received a compliance score of 58.1% (*Inadequate*) with three critical issues identified. This is a decrease of 21.9 percentage points from the score of 80.0% compliance achieved during the June 2018 annual audit. Four questions were rated in this component; one was rated proficient, and three were rated inadequate.

During the re-audit, two new issues were identified. The NCPR auditor's review of eight patient health records showed the nursing staff completed a face-to-face appointment with six patients upon their return from specialty service appointment (Question 10.2). The remaining two records did not contain the required documentation, resulting in 75.0% compliance. Two records were missing documentation showing the facility RN notified the PCP of any immediate medication or follow up requirements provided by the specialty consultant, resulting in 33.3% compliance (Question 10.3).

During the electronic health record review, the NCPR auditor reviewed six health records of patients returning from a specialty care appointment (Question 10.4). Documentation in two health records showed the provider saw the patient beyond the 14 calendar day time frame and two records did not have documentation showing the PCP saw the patient for a follow up appointment upon their return from specialty service appointments. The NCPR auditor found the remaining two patient health records

[16] Update: Upon inquiring with the facility regarding this patient, PPCMU auditors were informed the patient had paroled soon after the RFS was forwarded to the hub. Upon receiving this information, PPCMU management contacted the Deputy Medical Executive of Utilization Management to inform about the patient and the urgent need to bring the patient to the hub so that patient could be seen by a specialist. Subsequently, upon direction from the Deputy Medical Executive, the patient was brought back to the hub and the patient was seen by a specialist on October 18, 2018. The result from a Computerized Tomography (CT) scan of the neck did not reveal any abnormalities.

[17] Update: The physician auditor requested an update on this patient. The HSA reported this inmate was transported to Truxton Radiology for a mammogram on September 5, 2018. At the time, the radiologist refused to do the mammogram due to the patient's young age. The radiologist stated an ultrasound could be done only upon PCP's approval. Subsequently, the patient had a mammogram on September 28, 2018. The mammogram revealed the breast mass was benign and there was no malignancy; the radiologist recommended annual mammogram screening for the patient. A surgical evaluation no longer considered needed at this time.

compliant with this requirement, resulting in 33.3% compliance. This critical issue was initially identified during the May 2017 audit. This critical issue remains unresolved.

11. PREVENTIVE SERVICES

This component assesses whether the facility offers or provides various preventive medical services to patients meeting certain age and gender requirements. These include cancer screenings, tuberculosis evaluation, influenza and chronic care immunizations. 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.

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

Overall Score: *Not Applicable*

Quantitative Review Results

This component is reviewed once per calendar year during the annual audit. The requirements for this component will be evaluated for compliance during the next annual audit.

12. EMERGENCY MEDICAL RESPONSE/DRILLS and EQUIPMENT

For this component, the NCPR auditors review the facility's emergency medical response (EMR) documentation to assess the response time frames of the facility's health care staff during medical emergencies and/or drills. The NCPR auditor also inspects EMR bags and various emergency medical equipment to ensure regular inventory and maintenance of equipment is occurring. The compliance for this component is evaluated 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.

Case Review Score: *Not Applicable*
Quantitative Review Score: *85.0%*

Overall Score: 85.0%

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

McFarland Female Community Reentry Facility received an overall quantitative score of 85.0% (*Adequate*) with five previous critical issues resolved and one unresolved. Additionally, one new critical issue was identified. This is an increase of 27.5 percentage points from the previous inadequate score of 57.5%. Of the ten questions reviewed in this component, eight were rated proficient and two were rated inadequate.

During the June 2018 audit, the facility did not conduct an Emergency Medical Response Review Committee (EMRRC) meeting for three out of four months reviewed, scoring 25.0% compliance (Question

12.3). During the re-audit, the NCPR auditor found the facility conducted meetings in all four months of the audit review period, achieving 100% compliance. This critical issue is resolved.

The previous annual audit also identified the facility did not perform a timely review of incident packages submitted to the committee, and the facility did not use the appropriate documents required for review, resulting in 0.0% compliance (Question 12.4). During the re-audit, the NCPR auditor's review of EMRRC meeting minutes and incident packages showed two of the four packages did not contain the required documents. The incident package for the EMR drill conducted on June 15, 2018, did not contain a CDCR Form 7463, *First Medical Responder Data Collection Tool,* completed by nursing staff. The incident package for EMR drill conducted on July 23 did not include interdisciplinary progress notes; the nursing staff only utilized CDCR Form 7463 instead. Additionally, nursing staff did not document the patient's vital signs on CDCR Form 7463 during this EMR drill. This resulted in 50.0% compliance. This critical issue was first identified during the June 2016 audit when the facility was found 0.0% compliant. The facility continued to remain non-compliant during the May 2017 audit and November 2017 Limited Review scoring 0.0% and 66.7% respectively. This critical issue remains unresolved.

During the annual audit, auditors found the facility did not consistently inventory their EMR bag monthly (Question 12.7), and the bag did not contain all the required supplies (Question 12.8), resulting in 75.0% and 0.0% compliance respectively. During the re-audit, the NCPR auditor found the facility regularly inventoried their EMR bag, and it contained all required supplies, resulting in 100% compliance for both requirements. These two critical issues are now resolved.

The fifth critical issue identified during the annual audit resulted due to one of the facility's emergency medical equipment being non-operational (Question 12.14), resulting in 75.0% compliance. During the re-audit, an onsite inspection of the facility's emergency medical equipment showed all four pieces of equipment were fully operational, resulting in 100% compliance. This critical issue is resolved.

The final critical issue identified during the annual audit was related to the facility not implementing a Narcan Log to account for Narcan at the beginning and end of each nursing shift, scoring 0.0% (Question 12.15). During the re-audit, the NCPR auditor found the facility implemented a Narcan Log and Narcan was accounted for on all nursing shifts for the month audited and the facility achieved 100% compliance for this requirement. This critical issue is resolved.

One new critical issue was identified during the current re-audit. The facility's EMR documentation showed one incident warranted opening of the EMR bag. During the drill on September 22, 2018, the patient was unresponsive with possible overdose and oxygen non re-breather mask at 100% was used. However, upon reviewing the EMR bag log, the NCPR auditor could not find any documentation showing the facility opened, re-supplied, and resealed the EMR bag following its use during the EMR drill, resulting in 0.0% compliance (Question 12.6). In addition, the auditor noted Narcan was not administered to this patient during the drill for possible drug overdose.

13. CLINICAL ENVIRONMENT

This component measures the general operational aspects of the facility's clinic(s). The auditors, through staff interviews and onsite observations/inspections, determine whether health care management implements and maintains practices promoting infection control through general cleanliness, adequate hand hygiene protocols, and control of blood-borne pathogens and contaminated waste. Evaluation of this component is based entirely on the quantitative review results from the visual observations auditors make at the facility during their onsite visit, as well as review of various logs and documentation reflecting maintenance of clinical environment and equipment.

Case Review Score: *Not Applicable*
Quantitative Review Score: *98.8%*

Overall Score: 98.8%

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

The facility received an overall score of 98.8% (*Proficient*) with one previous critical issue resolved. This is an increase of 5.5 percentage points from the previous score of 93.3%. Fourteen of the 15 questions reviewed for this component received 100% compliance. The remaining question received a score of 83.3%.

During the June 2018 annual audit, the NCPR auditor identified two pieces of reusable medical instruments (forceps and a biopsy curette) did not have a sterilization date documented on the package, resulting in 0.0% compliance (Question 13.1). During the re-audit, the NCPR auditor noted all three pieces of reusable medical instruments had sterilization dates documented on the packets, resulting in 100% compliance. This critical issue is resolved.

During the June 2018 audit, the physician auditor noted the exam table in physician examination room was poorly placed. The door to the exam room locked when closed and could not be opened from outside except with a key. During the re-audit, the auditor noted better placement of the exam table and the exam rooms no longer locked automatically when closed.

14. QUALITY OF NURSING PERFORMANCE

The goal of this component is to provide an evaluation of the overall quality of health care provided to the patients by the facility's nursing staff. Majority of the patients selected for retrospective chart review were the ones with high utilization of nursing services, as these patients were most likely to be affected by timely appointment scheduling, medication management, and referrals to health care providers.

Case Review Score: ***74.8%***
Quantitative Review Score: *Not Applicable*

Overall Score: 74.8%

Case Review Results

The *Quality of Nursing Performance* component received a compliance score of 74.8% (*Inadequate*). This is a decrease of 8.7 percentage points from the previous June 2018 score of 83.5%. This determination is based upon the detailed case review of nursing services provided to ten patients housed at MFCRF during the audit review period of June through September 2018. Of the ten detailed case reviews conducted by the NCPR auditor, four were found adequate, and six were found inadequate. Of the 172 total nursing encounters assessed in the ten detailed cases, 45 deficiencies were identified and are discussed in more detail in the preceding components.

Below is a brief synopsis of each case the NCPR auditor determined the facility nursing staff's performance was inadequate.

Case Number	Deficiencies
Case 16	***Inadequate (58.1%).*** This is a 42-year old female patient with diagnosis of obesity, history of migraine headache, and borderline diabetes. During the review period the patient complained of painful thumb and was referred to the orthopedic clinic. The NCPR auditor reviewed a total of 31 encounters and identified 13 deficiencies. Six deficiencies were related to patient's untimely receipt of prescribed medications. The remaining seven deficiencies were related to inadequate or lack of documentation for the following: nursing assessment, establishment of EC, type of procedure performed on the patient, nurse's initials missing on the MAR, and failure to complete required transfer forms.
Case 18	***Inadequate (75.0%).*** This is a 31-year old female patient with diagnoses of left breast mass and latent tuberculosis (TB) infection. During the review period, the patient was monitored monthly for TB and referred to surgery clinic for biopsy of the breast lesions. The NCPR auditor reviewed a total of 20 encounters and identified five deficiencies related to non-documentation of EC, nursing assessment prior to specialty service appointment, type of specialty service performed on the patient, completion of required transfer document, and delay in signing of patient's CDCR Form 7225.
Case 19	***Inadequate (71.4%).*** This is a 52-year old female patient with chronic diagnoses of hepatitis C, methamphetamine dependence, and right mandibular mass. During the review period, ultrasound of the patient's neck showed dominant right submandibular mass consistent with lymphadenopathy, lymphadenitis, or other neoplastic etiology. The NCPR auditor reviewed a total of 21 encounters and identified six deficiencies: prescribed medications were not received timely on two occasions, there was no documentation on the CDCR Form 7225 of the treatment or procedure the patient refused on two occasions, the annual TB evaluation was not completed within the required timeframe, and a pending appointment was not reflected on the CDCR Form 7371.
Case 20	***Inadequate (66.7%).*** This is a 26-year old female patient with chronic diagnosis of hypertension. During the review period, the patient complained of dizziness with nausea and was sent out to the community hospital. The nurse auditor reviewed a total of 15 encounters and identified the following five deficiencies: nursing did not document review of discharge instructions upon patient's return from the hub following hospitalization; nursing did not complete the patient's PREA Screening form accurately; the patient did not receive her ordered medications timely on two occasions, and there was no documentation of weekly BP checks per PCP's order.
Case 21	***Inadequate (73.7%).*** This is a 28-year old female patient with chronic diagnoses of hepatitis C, migraine, and seizure. During the review period, the patient complained of headache, hemorrhoids, and insect bites. The NCPR auditor reviewed a total of 19 encounters and identified the following five

Case 23 ***Inadequate (57.1%).*** This is a 33-year old female patient with history of anemia and gonorrhea. During the review period, the patient complained of right upper chest pain and was sent out to the hospital five days later where she was found to have ventricular bigeminy and bradycardia. The NCPR auditor reviewed a total of seven encounters and identified three deficiencies: inappropriate nursing action related to a patient with chest pain and bradycardia; no available documentation showing nursing assessment prior to patient's transfer to the hospital, and no documentation of patient's refusal on CDCR Form 7225 when the patient refused a follow up mental health evaluation for elevated PREA risk.

During the current re-audit, MFCRF remains deficient on several issues related to nursing care. During the onsite audit, the NCPR auditor spent approximately two hours discussing the audit findings with the HSA and four facility nurses. The auditor discussed the reasons for non-compliance and recommended action plans to prevent their recurrence. Likewise, the NCPR had an hour long discussion with the Regional Director of Health Services and Executive Vice President of Health Services, of The GEO Group, Inc. regarding the same.

The NCPR auditor determined the facility's nursing care to be suboptimal and currently not meeting CCHCS compliance standards both quantitatively and qualitatively. One of the prime factors that could help alter the current situation is the serious involvement and cooperation of the facility's HSA who is not proactive in handling issues or deficiencies identified during the previous and current audits. Being in a leadership role of overseeing the quality and timeliness of health care delivery at MFCRF, and training and management of the facility's nursing staff, the HSA is expected to be more cooperative and responsive to the audit team's recommendations and suggestions. Effective nursing leadership is crucial to the facility's ability to successfully meet standards for quality nursing care.

RECOMMENDATIONS:

- Incumbent nurses should be oriented to the IMSP&P requirements and CCHCS nursing protocols. The facility should maintain and track the proof of practice for the orientation provided.
- The facility management should establish an early standard start time for Daily Care Team Huddles during business days when the clinic is in operation, and discuss patient care issues and plan of action during this huddle.
- The facility should develop a patient program regarding the importance of the sick call process with cooperation of custody staff, and should include the impact of refusals on the clinic operations and patients' merit system.
- Nursing staff must be trained on the proper documentation of patient refusal and EC for any treatment rendered or during discussion of treatment plans with patients.
- GEO management must ensure their health care staff have access to the IMSP&P online. Nursing orientation should include how to access online IMSP&P.
- Ready to use transfer packages must be prepared based on IMSP&P requirements for nurses to be familiar with the required transfer documents.
- The facility must develop a tracking method to ensure timely receipt of chronic care medications.
- GEO management should have a routine dialog or communication with the Women Advisory Committee (WAC) members to identify problem areas and promote patient satisfaction.
- The HSA must orient herself with the Health Care Incident Reporting System and then orient health care staff with the current procedures. The HSA must coordinate and work closely with the PPCMU NCPR regarding the resolution of the audit findings.

15. QUALITY OF PROVIDER PERFORMANCE

In this component, the physician auditor provides an evaluation of the adequacy of provider care at the facility. Appropriate evaluation, diagnosis, and management plans are reviewed for programs including, but not limited to, sick call, chronic care programs, specialty services, diagnostic services, emergency services, and specialized medical housing.

Case Review Score: 45.7%
Quantitative Review Score: *Not Applicable*

Overall Score: 45.7%

Case Review Results

Based on the detailed review of 15 cases conducted by the physician auditor, the facility provider's performance received a score of 45.7% compliance, equating to an overall quality rating of *Inadequate*. This is a decrease of 10.1 percentage points from the previous score of 55.8%. Of the 16 detailed case reviews conducted, 5 were rated proficient and 11 were rated inadequate. Out of a total of 46 provider encounters/visits assessed, 30 deficiencies were identified.

The facility currently has one PCP providing care to the patient population at MFCRF. Overall provider performance has not been adequate to protect inmates against risks of harm. The PCP has not been trained to practice in accordance with CCHCS guidelines. As a result, he also seems to prescribe excessively, and without adequate documentation of exam and assessments similar to the prior provider reviewed during the June 2018 annual audit. The previous provider's departure from MFCRF has not resolved the issue of inadequate PCP care and will not likely be resolved until the current provider is able to provide adequate care.

Below is a brief synopsis of each case the physician auditor determined the facility provider's performance to be inadequate.

Case Number	Deficiencies
Case 1	***Inadequate (33.3%).*** This 28 year old patient reported history of oral herpes (herpes labialis) during the audit review period. The PCP's exam suggested early rash at corner of mouth and PCP prescribed acyclovir. The PCP also prescribed medications for marginal indications, namely, artificial tears with no evidence of abnormal eye condition, Motrin for putative menstrual cramps, and hydrocortisone cream for dry skin. The patient was enrolled in chronic care for asthma. The PCP did not modify drug regimen after control assessment showed less than good control. Chronic care for asthma inadequate.
Case 3	***Inadequate (14.3%).*** This 24 year old patient with asthma complained of vaginal discharge, headache, and abdominal pain during the audit review period. Assessment and treatment appropriate for asthma, inappropriate antibiotic treatment without exam for reported vaginal discharge. Incomplete assessment of headaches and purported abdominal pains. Prescriptions of NSAIDs inappropriate for abdominal pain. Care overall inadequate, PCP relying on nurse's diagnosis and failed to supervise nurses using wrong protocols (muscular pain protocol for abdominal pain complaint).
Case 4	***Inadequate (50.0%).*** This 30 year old morbidly obese patient was seen for complaints of rash, described as non-specific. Per PCP's note, rash appeared to be PR and Zithromax was ordered. "Non-specific" does not describe a rash sufficiently to diagnose. The PCP should be seeking consultations from his colleagues or even conversing with dermatology specialist for rashes he cannot diagnose with confidence. Patient also complained of excessive vaginal bleeding. No lab ordered, no pelvic exam documented, and no consultation with specialist ordered. Complete blood count showed anemia;

	however, test was not ordered until the following week. The PCP does not consult when he should. Obese patient is at relatively high risk for endometrial cancer, not unknown to occur at age 30 (1.5% of cases). Overall inadequate care because of poor management when patient presented with rash.
Case 6	***Inadequate (50.0%).*** This 32 year old patient with history of obesity and gall bladder surgery complained of right hand pain at the time of intake screening. The patient has no prior medical problems and is not on any medications when at the previous facility until March 2018. The PCP diagnosed the patient's hand pain as "R Carpal Tunnel Syndrome" with no reported evidence to substantiate the diagnosis, and no follow up on his therapy of using a "right hand brace". Failure to engage in evidence based practice falls below applicable standards of care.
Case 7	***Inadequate (0.0%).*** This 41 year old morbidly obese pre-diabetic patient with history of hypertension, episodic chest pain, metabolic syndrome, and hyperlipidemia was prescribed nitroglycerin, Lipitor, aspirin, and advised to diet and exercise during the audit review period. The patient was prescribed two anti-hypertensive drugs, nifedipine and atenolol, at the same time. The scheduled 30-day follow up was insufficient to monitor weight and chest pain in this setting. Lab testing not repeated. Refusal to see PCP documented for September 4, 2018, with no follow up by PCP. Simultaneous treatment with beta blocker and calcium channel blocker exposes patient to unreasonable risk of severe bradycardia. No indication in the medical record the PCP has tried to establish a diagnosis to justify treating purported chest pain with nitroglycerin. The physician auditor did not see evidence of any ischemic heart disease. Overall care is inadequate.
Case 8	***Inadequate (0.0%).*** This 44 year old patient with anemia of uncertain cause was scheduled for follow up after lab tests but lab test was not done per PCP's order, and no follow up ordered for 90 days. Lab tests completed on August 31, 2018, indicate life threatening anemia. The patient's chart shows no evidence of action taken and follow up. Patient's anemia worsens considerably while under PCP's care, probably because of his failure to monitor. Care provided is inadequate and possibly dangerous.
Case 9	***Inadequate (0.0%).*** This 49 year old patient was diagnosed with type 2 diabetes in 2017. The patient frequently resisted treatment advice during the review period and was followed up by mental health services for depression. The patient complained of back pain and was referred to the PCP, but there was no documentation of PCP exam or follow up. A blood test was ordered for the patient. However, the follow up on lab test was poor. No HbA1c test done in nearly nine months. Patient's blood sugar and weight not followed up, even intermittently while on medications. Overall care is inadequate.
Case 10	***Inadequate (0.0%).*** This 34 year old patient was treated by Mental Health for depression, Post-Traumatic Stress Disorder, and amphetamine abuse. The patient has a vague history of asthma, not currently symptomatic or requiring medications. The patient was diagnosed with obesity and reported irregular menses during the review period. The patient complained of blood in stool on July 31, 2018. However, no work up documented. The PCP prescribed BCP for vaginal spotting with no documented exam to rule out cervical disease and uterine pathology. No CBC test ordered to rule out anemia. Follow up ordered for 90 days. Treatment with BCP before and without testing to rule out endometrial disease, pregnancy or other organic conditions related to spotting is beneath standard of care. Also a complaint of blood is stool must be investigated. Care is severely deficient.
Case 11	***Inadequate (33.3%).*** This 50 year old patient with history of HCV had a lab test on January 23 and February 16, 2018, confirming substantial viral load. The patient was diagnosed with vaginitis during the audit review period and treatment provided without microscopic exam of discharge. The patient was also diagnosed as having neck mass consistent with lymphadenopathy or cancer on ultrasound. Patient referred for surgical evaluation and possible biopsy/excision. No apparent discussion with surgery or medical colleagues regarding the ultrasound finding. No repeat lab testing to evaluate for cocci, or occult TB. No follow up on surgery appointment. Hepatitis C is now treated in all cases that have not spontaneously remitted. Referral to hub is mandatory but was not done in this case. Overall care provided is inadequate.

Case 12	***Inadequate (0.0%).*** This 30 year old patient was diagnosed with breast mass during physical exam and confirmed by ultrasound in April 2018. Surgical evaluation/biopsy/excision was recommended but not done at the time of this review. No follow up documented in patient's record indicated date for surgery consultation/treatment. Patient was treated for minor acne with a prescription of benzoyl peroxide which is unnecessary and may aggravate patient's existing dry skin condition. Delay in surgery attention for suspicious breast lesion is not consistent with community standards and is inadequate care. Also unnecessary treatment of mild acne not appropriate for prison setting.
Case 15	***Inadequate (50.0%).*** This is a 33 year old patient with Hodgkin's Lymphoma in remission. The patient was treated for a headache complaint without PCP exam and a blood test was scheduled for three months during the review period. Although intake was adequate, subsequent care provided was improper as treatment without exam is disfavored and possibly violates Medical Practice Act.

During the onsite audit, the physician provider spent time observing the PCP provide care to patients and discussed the case review findings with him. The auditor also observed the Daily Care Team Huddle. The auditor determined the morning huddles with PCP, nursing staff, and custody will benefit from physician leadership. There seems to be little discussion regarding management of difficult challenges in patient care. This is unchanged since the June 2018 audit. Nursing review substantiates these concerns, finding access to care, medication administration, referrals, return from hospital/specialty care, and follow ups do not comport with standards of care established for CDCR patients. The PCP and nurses do not appear to be working together to achieve the goal of compliance with CCHCS guidelines/protocols/requirements.

During the course of conversation with the PCP, the physician auditor found the PCP has received no training in regards to CCHCS protocols and guidelines. The CCHCS guidelines are still not available in his office as previously identified by the auditor during the June 2018 audit. Although the auditor had previously showed the PCP how to access CCHCS guidelines in June, the PCP stated he was not aware what CCHCS meant, or how to access its protocols. The PCP has also not received any training to guide him for providing obstetrician/gynecologist (ob-gyn) care in a correctional facility setting. This is unchanged since the June 2018 audit. There are no weekly or monthly quality assurance programs. The PCP's work appears to have not been monitored by his employers (GEO).

Overall provider performance has not been adequate to protect patients against risks of harm, as evidenced in case reviews conducted during the previous and current audits. The facility's previous provider appeared to prescribe medications without exam and unnecessarily. The current provider has also not been trained to practice in accord with CCHCS guidelines. As a result, he too seems to prescribe excessively and without adequate documentation of exam and assessments. The previous provider's departure from MFCRF has not resolved the issue of inadequate PCP care and will not likely be resolved until a new provider is able to provide adequate care.

The GEO leadership (Dr. Christakis and Dr. Alvarez) agreed with the physician auditor's case review findings indicating the care provided by the PCP was not adequate in 11 out of 16 cases reviewed for time period of June through September 2018. The lapses fell into the following general categories:

- Prescription of medications without exam, diagnosis, or sufficient clinical basis
- Poor control of Asthma, use of non-formulary drug to treat asthma
- Failure to provide diagnosis for symptoms or complaints
- Treatment with medications not indicated for diagnosis
- Failure to consult with specialists or medical colleagues at GEO
- Failure to follow up on patients at high risk of adverse outcomes

- Failure to follow up on abnormal laboratory and radiology results
- Failure to follow CCHCS protocols or formulary

Moreover, the PCP did not address concerns some patients raised following the case reviews in September 2018.

Additional Deficiencies Identified During the Onsite Visit

The physician auditor reviewed additional patient charts while onsite and discussed his findings from the onsite reviews with GEO Group's Executive Vice President Health Services and the Chief Medical Officer. The deficiencies identified during the onsite chart reviews are listed below:

- A 55 year old, morbidly obese patient with substantial risks of side effects from polypharmacy was prescribed Amitriptyline, Robaxin (not on CCHCS formulary and not indicated for this patient), Hydroxyzine, nifedipine, metoprolol, and nitroglycerine. Her workup and diagnosis to explain chest pain is not documented. The metoprolol, nitroglycerine, Robaxin and hydroxyzine are not being prescribed currently. But as of November 7, 2018, no referral has been made to cardiology.
- A 37 year old morbidly obese patient being treated with anti-thyroid medications for aggressive Hashimotos Thyroiditis. On September 25, 2018, Thyroid Stimulating Hormone (TSH) was very low indicating hyperthyroidism was not controlled; no documented consult with endocrinology.
- A 25 year old patient with history of asthma being treated with Singulair. She has good peak flows and no asthma symptoms. As of November 7, 2018, asthma is not well controlled. The patient is currently on non-formulary Alvesco. The follow up is inadequate for uncontrolled asthma.
- A 29 year old patient with low peak flows, borderline subjective reports regarding control of asthma, and also complaining of poor bladder control, notes from October 30, 2018, shows asthma is poorly controlled. No consultation or follow up. Patient was evaluated by RN for suicidal ideation on September 20, 2018.

The physician auditor interviewed four Women's Advisory Committee (WAC) members regarding quality of care provided by the PCP and nursing staff at MFCRF. The following issues were brought to the auditor's attention to be reviewed by GEO leadership:

- One WAC member was not provided treatment timely for heavy dysfunctional uterine bleeding; this patient required transfer to the hub due to lack of treatment at MFCRF. The patient was sent out to the Emergency Room six days after blood loss had occurred. The patient was prescribed Benadryl and dicyclomine, both drugs not indicated for this condition. There was no record of pelvic exam to rule out endometritis; no treatment for anovulatory[18] cycle to stop bleeding (BCP 5 per day x 4 days); no purpose to prescribe dicyclomine, no purpose to prescribe Benadryl, and delayed treatment of bleeding.
- Another WAC member complained of weight gain and difficulty losing weight. The auditor observed the patient had facial hirsutism[19]. No pelvic exam, ultrasound, or labs in medical record to evaluate for possible polycystic ovary syndrome.

[18] Anovulation is when the ovaries do not release an oocyte during a menstrual cycle. Therefore, ovulation does not take place.
[19] Hirsutism (HUR-soot-iz-um) is a condition of unwanted, male-pattern hair growth on face, chest and back in women.

- A third WAC member had reported "thumb pain." The exam documented in this patient's chart stated "no bruise/hematoma." There is no documentation of any motor exam or range of motion to rule out tendon injury. The patient appears to have lost pollicis longus[20] function. Possibly missed opportunity for repair of ruptured tendon soon after injury.
- A patient was described as violent and anti-social. No PCP progress note in the health record. No labs ordered. No mental health counseling/services provided.
- The WAC members reported a patient described by fellow inmates as exhibiting psychotic behavior. Evaluation done by an RN. No PCP exam documented. No mental health counseling/services provided.

Overall, the medical care provided by the PCP at MFRCF does not meet the applicable standards set forth by CCHCS guidelines. Deficits described above are much the same as noted in the previous review of this PCP's care during the June 2018 audit. The auditors were informed by GEO leadership the PCP is scheduled to leave MFCRF on November 15, 2018[21]. The physician auditor offers the following recommendations for the incumbent clinician hired to provide care to MFCRF patients.

RECOMMENDATIONS:

- The new physician's orientation should include visit to CDCR hub institution, CCWF, for at least one full day of instruction and "shadowing" of ob-gyn and general medicine providers.
- Training should familiarize new hires with CCHCS protocols, formulary, and resources for further information (CDCR intranet, Up-to-date) and/or consultation (GEO leadership, hub physicians, specialists).
- Monitoring under GEO auspices should begin immediately after hire and continue with follow up training.
- Mental health services and/or mental health counseling should be provided on site.
- Clinician should schedule patients for return visits until problems are resolved.
- The management should consider hiring a Nurse Practitioner or Physician's Assistant as back-up providers to ensure continued care.
- The facility's health care staff should develop a culture of cooperation with custody in order to facilitate smooth operation of the clinic.
- The facility management should promote a leadership role for the provider.

[20] Abductor pollicis longus (APL) is one of the extrinsic muscles of the hand. Its major function is to abduct the thumb at wrist.

[21] Subsequent to the audit, the facility management submitted credentialing packets for two providers which are currently under review by the CCHCS Credentialing Verification Unit.

PRIOR CRITICAL ISSUE RESOLUTION

The previous annual audit conducted June 5 through 7, 2018, resulted in the identification of 22 critical issues. During the re-audit, auditors found 10 of the 22 issues resolved. Below is a discussion of these critical issues.

Critical Issue	Status	Comment
Question 1.2 *THE FACILITY'S POLICIES/LOCAL OPERATING PROCEDURES ARE NOT ALL IN COMPLIANCE WITH THE INMATE MEDICAL SERVICES POLICIES AND PROCEDURES.*	**Unresolved**	This critical issue was identified during June 2018 annual audit. The auditors found 8 of the facility's 15 LOPs to be non-compliant with IMPS&P (46.7%). During the re-audit, 9 of the 15 LOPs were found non-compliant (40.0%). ***This critical issue is unresolved and will be evaluated for compliance during subsequent audits.***
Question 1.4 *THE FACILITY'S INMATE ORIENTATION HANDBOOK DOES NOT ACCURATELY DESCRIBE THE HEALTH CARE GRIEVANCE AND SICK CALL PROCESS.*	**Resolved**	This critical issue was first identified during the November 2017 limited review. The facility's Inmate Orientation Handbook did not accurately describe the health care grievance process (0.0%). During the June 2018 audit, the handbook had not been updated and remained non-compliant. During the re-audit, the auditor found the grievance process noted in the handbook had been updated and accurately described the current grievance process (100%). ***This critical issue is resolved.***
Question 2.4 *THE FACILITY DID NOT SUBMIT ALL THE WEEKLY AND MONTHLY MONITORING LOGS WITHIN THE SPECIFIED TIME FRAMES DURING THE AUDIT REVIEW PERIOD.*	**Unresolved**	This critical issue was identified during the June 2018 annual audit. At the time, the facility did not submit 13 out of 59 monitoring logs timely during the audit review period (78.0%). During the re-audit, the facility did not submit 19 out of 59 monitoring logs within the required time frame (67.8%). ***This critical issue is unresolved and will be evaluated for compliance during subsequent audits.***
Question 2.5 *THE FACILITY DOES NOT ACCURATELY DOCUMENT ALL THE DATA ON THE SICK CALL MONITORING LOG.*	**Unresolved**	This critical issue was identified during the June 2018 annual audit. At the time, the facility's Sick Call Monitoring Log had erroneous information for 4 of the 17 entries reviewed (76.5%). During the re-audit, the auditor found 6 of the 17 entries contained erroneous information (64.7%). ***This critical issue is unresolved and will be evaluated for compliance during subsequent audits.***
Question 2.6 *THE FACILITY DOES NOT CONSISTENTLY DOCUMENT ALL THE DATES ON THE SPECIALTY CARE MONITORING LOG.*	**Unresolved**	This critical issue was identified during the June 2018 annual audit. At the time, the facility's Specialty Services Monitoring Log had erroneous information for two of the seven entries reviewed (71.4%). During the re-audit, the auditor found 4 of the 10 entries contained erroneous information (60.0%). ***This critical issue is unresolved and will be evaluated for compliance during subsequent audits.***
Question 2.10 *THE FACILITY DID NOT HAVE A SUPPLY OF THE CDCR FORM 602-HC A, HEALTH CARE*	**Resolved**	This critical issue was identified during the June 2018 annual audit. At the time, one of the facility's four housing units did not have a supply of

GRIEVANCE ATTACHMENT AVAILABLE IN ALL THE HOUSING UNITS.		the CDCR Form 602-HC A (75.0%). During the re-audit, the auditor found a supply of CDCR Form 602- HC A were readily available in all four housing units (100%). ***This critical issue is resolved.***
Question 2.12 *THE HEALTH CARE GRIEVANCE LOG DOES NOT CONTAIN ALL THE REQUIRED INFORMATION.*	**Resolved**	This critical issue was identified during the June 2018 annual audit. At the time, the facility had not updated the health care grievance tracking log to reflect the changes in the health care grievance regulations. The log did not contain all the required columns and information (0.0%). During the re-audit, the auditor found the health care grievance log had been updated and contained all the required columns and information (100%). ***This critical issue is resolved.***
Question 2.13 *THE FACILITY DOES NOT CONSISTENTLY PROCESS INSTITUTIONAL LEVEL HEALTH CARE GRIEVANCES (FORMERLY APPEALS) IN THE SPECIFIED TIME FRAMES.*	**Unresolved**	This critical issue was identified during the June 2018 annual audit. At the time, the auditor reviewed seven health care grievances and found six were not processed within the required time frame (14.3%). During the re-audit, the auditor reviewed six health care grievances and found three were not processed within the required time frame (50.0%). ***This critical issue is unresolved and will be evaluated for compliance during subsequent audits.***
Question 3.3 *THE FACILITY DOES NOT HAVE A TRACKING LOG DOCUMENTING THAT HEALTH CARE STAFF ARE RECEIVING TRAINING.*	**Unresolved**	This critical issue was identified during the June 2018 annual audit. At the time, the facility HSA was unable to provide a log tracking health care staff training (0.0%). During the re-audit, the facility again did not submit a tracking log for training (0.0%). ***This critical issue is unresolved and will be evaluated for compliance during subsequent audits.***
Question 4.8 *THE FACILITY DOES NOT ADEQUATELY DOCUMENT THE DAILY CARE TEAM HUDDLE ON THE DAILY HUDDLE ACTIVITY SHEET.*	**Unresolved**	This issue was initially identified during the May 2017 audit. The Daily Care Team Huddle documentation for 14 of the 20 days reviewed was found to be non-compliant (70.0%). During the November 2017 and May 2018 audits, the facility remained non-compliant for this requirement scoring 77.3% and 0.0% respectively. During the re-audit, the NCPR auditor reviewed the documentation from the Daily Care Team Huddles held during the 19 business days in September 2018 and found there was adequate documentation for 14 days (73.7%). ***This critical issue is unresolved and will be evaluated for compliance during subsequent audits.***
Question 5.2 *THE FACILITY'S STAFF DO NOT CONSISTENTLY COMPLETE PATIENT DIAGNOSTIC TESTS WITHIN THE TIME FRAME SPECIFIED BY THE PRIMARY CARE PROVIDER (PCP).*	**Resolved**	This critical issue was identified during the June 2018 annual audit. At the time, NCPR auditor reviewed 12 patient health records and four records revealed the diagnostic tests were not completed by nursing staff within the time frames specified by the PCP (66.7%). During the re- audit, of the 15 health records reviewed, one record revealed the patient's diagnostic test(s) was not completed timely (93.3%). ***This critical is resolved.***

Question 7.8 *THE FACILITY DOES NOT INCLUDE ALL THE REQUIRED TRANSFER DOCUMENTS AND MEDICATIONS IN THE TRANSFER ENVELOPE.*	**Unresolved**	This critical issue was identified during the June 2018 annual audit. At the time, NCPR auditor reviewed three transfer envelopes and found one envelope did not contain all the required documents (66.7%). During the re-audit, the auditor interviewed three nursing staff regarding the transfer process since there were no patients scheduled to transfer during the onsite audit. Of the three nursing staff interviewed, two RNs were not knowledgeable about the required documents to be included in the Transfer Envelope (33.3%). ***This critical issue is unresolved and will be evaluated for compliance during subsequent audits.***
Question 8.1 *THE PATIENTS CHRONIC CARE MEDICATIONS ARE NOT CONSISTENTLY RECEIVED BY THE PATIENTS WITHIN THE REQUIRED TIME FRAME.*	**Unresolved**	This critical issue was first identified during the June 2016 audit. The NCPR auditor reviewed 28 health records and found five patients did not receive their chronic care medications timely (82.1%[22]). During the May 2017, November 2017, and June 2018 audits, the facility remained non-compliant for this requirement having received failing compliance scores of 16.7%, 6.3%, and 12.5% respectively. During the re-audit, the NCPR auditor reviewed 16 health records and found 10 records were non-compliant (37.5%). ***This critical issue is unresolved and will be monitored during subsequent audits for compliance.***
Question 10.4 *THE FACILITY'S PCP DOES NOT CONSISTENTLY REVIEW THE SPECIALTY CONSULTANT'S REPORT/DISCHARGE SUMMARY AND COMPLETE A FOLLOW-UP APPOINTMENT WITH THE PATIENT WITHIN THE REQUIRED TIME FRAME UPON THE PATIENT'S RETURN FROM A SPECIALTY SERVICES APPOINTMENT.*	**Unresolved**	This critical issue was first identified during the May 2017 audit. The NCPR auditor reviewed 14 health records and found 5 records did not have documentation showing the PCP reviewed the specialty consultant's report/discharge summary and completed a follow-up appointment with the patient within the required time frame upon the patient's return from a specialty appointment (64.3%). During the November 2017 and May 2018 audits, the facility remained non-compliant for this requirement, having received failing compliance scores of 75.0% and 50.0% respectively. During the re-audit, the auditor reviewed six health records and four were found non-compliant (33.3%). ***This critical issue is unresolved and will be evaluated for compliance during subsequent audits.***
Question 11.3 *THE FACILITY DOES NOT CONSISTENTLY OFFER COLORECTAL CANCER SCREENING TO PATIENTS WHO ARE BETWEEN 50 AND 75 YEARS OF AGE.*	**Unresolved**	This critical issue was initially identified during the May 2017 audit. Two of the five records reviewed showed MFCRF did not offer colorectal cancer screenings to two patients (60.0%). This question was not rated during the November 2017 Limited Review as this question is reviewed annually. During the June 2018 annual audit, two of three (66.7%) health records showed that patients received a colorectal cancer screening during the audit review period. This issue was not evaluated during the current audit as this question is

[22] During the June 2016 audit, per the methodology, the facility was required to obtain a compliance score of 85.0% or greater to be compliant.

		reviewed once per calendar year during the annual audit. ***This critical issue remains unresolved and will be evaluated for compliance during subsequent audits.***
Question 12.3 *THE FACILITY DOES NOT CONSISTENTLY HOLD AN EMERGENCY MEDICAL RESPONSE REVIEW COMMITTEE (EMRRC) MEETING ON A MONTHLY BASIS DURING THE AUDIT REVIEW PERIOD.*	**Resolved**	This critical issue was identified during the June 2018 audit. At the time, the NCPR auditor reviewed the EMR meeting minutes for the audit review period and found the facility did not conduct EMRRC meetings for three out of four months reviewed (25.0%). During the re-audit, NCPR auditor reviewed meeting minutes for four months and found the facility conducted EMRRC meetings in all four months of the audit review period (100.0%). ***This critical issue is resolved.***
Question 12.4 *THE EMRRC DOES NOT PERFORM TIMELY REVIEW OF INCIDENT PACKAGES SUBMITTED TO THE COMMITTEE AND THE FACILITY STAFF FAILS TO USE THE DOCUMENTS REQUIRED FOR REVIEW BY THE COMMITTEE.*	**Unresolved**	This critical issue has been outstanding since the June 2016 audit. At the time, the NCPR auditor reviewed seven incident packages and none had all required documents (0.0%). During the May 2017 audit, out of eight incidents occurred, the facility failed to submit documentation of five incidents to the EMRRC and the EMRRC failed to review/discuss the remaining three incidents timely during the EMRRC meetings (0.0%). During the November 2017 Limited Review, four of the six actual medical emergencies or medical drills were reviewed timely (66.7%). During the June 2018 audit, none of the three incident packages included the correct paperwork (0.0%). During the re-audit, four incident packages were reviewed and only two packages had the required documents, resulting in 50.0% compliance. ***This critical issue remains unresolved and will be evaluated for compliance during subsequent audits.***
Question 12.7 *THE FACILITY DOES NOT CONSISTENTLY INVENTORY THE EMERGENCY MEDICAL RESPONSE (EMR) BAG ON A MONTHLY BASIS.*	**Resolved**	This critical issue was identified during the June 2018 audit. At the time, NCPR auditor inspected the EMR bag log of the audit review period and found the facility had inventoried the EMR bag during three out of four months reviewed (75.0%). During the re-audit, inspection of the EMR bag log showed the facility inventoried the EMR bags during all four months of the audit review period (100.0%). ***This critical issue is resolved.***
Question 12.8 *THE FACILITY'S EMR BAG DOES NOT HAVE ALL THE REQUIRED SUPPLIES LISTED ON THE FACILITY'S EMR BAG CHECKLIST.*	**Resolved**	This critical issue was identified during the June 2018 audit. At the time, the NCPR auditor reviewed the EMR bag and found the EMR bag did not contain all the supplies listed on the facility's EMR bag checklist (0.0%). During the re-audit, an inspection of the EMR bag onsite showed the bag contained all the supplies listed on the checklist (100.0%). ***This critical issue is resolved.***
Question 12.14 *THE FACILITY DOES NOT HAVE ALL EMERGENCY MEDICAL EQUIPMENT FUNCTIONAL AND OPERATIONALLY READY.*	**Resolved**	This critical issue was identified during the June 2018 audit. At the time, the NCPR auditor inspected the facility's emergency medical equipment and found the facility's portable suction device was not operational (0.0%). During the re-

		audit, the NCPR auditor found all of the facility's emergency medical equipment were operational (100.0%). ***This critical issue is resolved.***
Question 12.15 *THE FACILITY STAFF DOES NOT ACCOUNT FOR NALOXONE (NARCAN) AT THE BEGINNING AND END OF EACH SHIFT.*	**Resolved**	This critical issue was identified during the June 2018 audit. During the June 2018 audit, the NCPR auditor found the facility did not maintain a Narcan log to account for Narcan at the beginning and end of each nursing shift (0.0%). During the re-audit, the NCPR auditor found the facility had implemented a Narcan Log and health care staff documented a count for Narcan during all shifts for the audit review period (100.0%). ***This critical issue is resolved.***
Question 13.1 *THE PACKAGED STERILIZED REUSABLE MEDICAL EQUIPMENT ARE NOT WITHIN THE EXPIRATION DATES.*	**Resolved**	This critical issue was identified during the June 2018 audit. At the time, the NCPR auditor identified two pieces of reusable medical instruments and neither instrument had a sterilization date documented on the package (90.0%). During the re-audit, the NCPR auditor inspected three pieces of reusable medical instruments and found all three packages had the sterilization dates documented on them (100.0%). ***This critical issue is resolved.***

CONCLUSION

The audit findings documented in this report are a result of an in-depth assessment of the health care services provided by MFCRF health care staff to CDCR patients during the audit review period of June through September 2018. The facility's overall performance during this time frame is rated at 67.5% (*Inadequate*), which is a decrease of 9.5 percentage points from the June 2018 annual audit. The facility did not resolve 12 out of 22 previous critical issues and 18 new critical issues were identified during the re-audit, resulting in a total of 30 current critical issues. Of the 13 components evaluated, auditors found 2 components to be proficient, 1 adequate, and 10 inadequate (refer to the *Executive Summary* on page four for additional details). The facility's overall compliance scores for 11 of the 13 components evaluated decreased since the June 2018 annual audit.

The most significant deficiency identified during the June 2018 and current re-audit is the inadequate care provided by the facility's PCP to the patient population. In spite of identifying a number of issues with the provider care during the June 2018 audit, such as, the PCP practicing polypharmacy, not following up on patients timely, prescribing medications without adequate exams and diagnoses, not being familiar with the CCHCS guidelines and care protocols, formulary, and poor follow up and communication with hub physicians and specialty consultants, has placed the CDCR patient population in imminent danger due to patients not receiving adequate and appropriate care in a timely manner. The facility management and GEO leadership has failed to provide close supervision, training, and mentoring to the provider although the importance of this was communicated to the facility management during the June 2018 audit. The management and GEO leadership is recommended they ensure the incumbent provider is provided the proper training and encouraged to communicate with the hub physicians in order to get well acquainted with providing adequate care to the patient population in accordance with CCHCS standards.

Since the June 2016 annual audit, MFCRF has struggled with critical issues, namely, failure to update the facility's LOPs timely and review them annually, not submitting the weekly and monthly monitoring logs timely, and not completing the weekly and monthly monitoring logs accurately and adequately. The facility was non-compliant for three critical issues consecutively during the past four audits. Three critical issues require the facility's immediate attention: documentation of Daily Care Team Huddles on the Daily Huddle Activity Sheet, failure to provide chronic care medications to patients within the specified timeframes, and documentation of incident packets for submission to the EMRRC.

Please see the table below showing the facility's score (*pass/fail*) for each of the facility's current critical issues failing to meet the required minimum compliance threshold since June 2016.

Critical Issue	6/2016 Audit	5/2017 Audit	11/2017 Audit	6/2018 Audit	11/2018 Audit
Question 1.2 The facility's local operating policies and procedures are not all in compliance with the Inmate Medical Services Policies and Procedures.	Fail	Fail	Pass	Fail	Fail
Question 2.4 The facility did not submit the required monitoring logs by the scheduled date per Private Prison Compliance and Monitoring Unit program standards.	Fail	Pass	N/A	Fail	Fail

Question 2.5 The facility does not accurately document all data in the sick call monitoring log.	Fail	Pass	N/A	Fail	Fail
Question 2.6 The facility does not consistently document all data on the specialty care monitoring log.	Fail	Fail	Pass	Fail	Fail
Question 2.13 The facility does not consistently process institutional level health care grievances within specified time frames	Pass	Fail	Pass	Fail	Fail
Question 4.8 The facility does not adequately document Daily Care Team huddle on the Daily Care Huddle Activity Sheet.	N/A	Fail	Fail	Fail	Fail
Question 7.8 The facility's nursing staff are not all knowledgeable about the required transfer documents to be included in the inter-facility Transfer Envelope.	Pass	Fail	Pass	Fail	Fail
Question 8.1 The patients' chronic care medications are not consistently received by the patients within the required time frame.	Pass	Fail	Fail	Fail	Fail
Question 10.4 The facility PCP does not consistently review the specialty consultant report/discharge summary and complete a follow-up appointment with the patient within the required time frame upon the patient's return from a specialty services appointment.	Pass	Fail	Fail	Fail	Fail
Question 12.4 The facility's incident packages submitted to the Emergency Medical Response Review Committee (EMRRC), failed to include the required review documents or failed to be reviewed timely by the EMRRC.	Fail	Fail	Fail	Fail	Fail

The auditors found the overall delivery of health care at MFCRF to be inadequate as previously identified during the annual audit. The facility has not made any significant effort to address the critical issues and bring them into compliance. The facility lacks consistent health care staff and leadership, the PCP is not meeting the standards set forth by CCHCS, and the HSA does not appear to be working cohesively with the provider in ensuring adequate patient care. It is imperative The GEO Group health care management work together to change the current health care practices at MFCRF by providing adequate training to all health care staff, encouraging the provider to take a leadership role in mentoring the nursing staff, and ensuring health care staff work cohesively with custody staff to form a well-functioning team to facilitate provision of adequate and timely care to the patient population at MFCRF.

APPENDIX A – QUANTITATIVE REVIEW RESULTS

McFarland Female Correctional Reentry Facility Range of Summary Scores: 33.3% - 98.8%	
Audit Component	**Quantitative Score**
1. Administrative Operations	92.5%
2. Internal Monitoring & Quality Management	75.1%
3. Licensing/Certifications, Training & Staffing	50.0%
4. Access to Care	92.4%
5. Diagnostic Services	90.5%
6. Emergency Services & Community Hospital Discharge	33.3%
7. Initial Health Assessment/Health Care Transfer	64.3%
8. Medical/Medication Management	81.0%
9. Observation Cells (COCF)	Not Applicable
10. Specialty Services	58.1%
11. Preventive Services	Not Applicable
12. Emergency Medical Response/Drills & Equipment	85.0%
13. Clinical Environment	98.8%
14. Quality of Nursing Performance	Not Applicable
15. Quality of Provider Performance	Not Applicable

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
		RA	7	0	100.0%	
1.2	Does the facility have current and updated written health care policies and local operating procedures in compliance with *Inmate Medical Services Policies and Procedures* guidelines?	A	7	8	46.7%	+20.0
		RA	6	9	66.7%	
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
		RA	1	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
		RA	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	1	0	100.0%	0.0
		RA	1	0	100.0%	
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
		RA	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	16	4	80.0%	+20.0
		RA	10	0	100.0%	
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	19	1	95.0%	+5.0
		RA	10	0	100.0%	
	Overall Percentage Score and Change			**Annual**	**77.7%**	**+14.8**
				Re-Audit	**92.5%**	

Comments:

1.2 The auditors' review of the facility's 15 LOPs showed 9 were non-compliant with IMSP&P, resulting in a 40.0% compliance score.

2. Internal Monitoring and 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%	0.0
		RA	4	0	100.0%	
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
		RA	2	2	50.0%	
2.3	Did the Quality Management Committee's review process include monitoring of defined aspects of care?	A	4	0	100.0%	0.0
		RA	2	0	100.0%	
2.4		A	4	13	78.0%	-10.2

	Did the facility submit the required monitoring logs by the scheduled date per Private Prison Compliance and Monitoring Unit program standards?	RA	40	19	67.8%	
2.5	Is data documented on the sick call monitoring log accurate?	A	13	4	76.5%	-8.7
		RA	11	6	64.7%	
2.6	Is data documented on the specialty care monitoring log accurate?	A	5	2	71.4%	-11.4
		RA	6	4	60.0%	
2.7	Is data documented on the hospital stay/emergency department monitoring log accurate?	A	3	0	100.0%	-50.0
		RA	1	1	50.0%	
2.8	Is data documented on the chronic care monitoring log accurate?	A	16	4	80.0%	-21.2
		RA	10	7	58.8%	
2.9	Is data documented on the initial intake screening monitoring log accurate?	A	19	1	95.0%	-20.0
		RA	26	6	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	3	1	75.0%	+25.0
		RA	4	0	100.0%	
2.11	Are patients able to submit the CDCR Forms 602-HC, *Health Care Grievances,* on a daily basis in all housing units?	A	4	0	100.0%	0.0
		RA	4	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
		RA	2	0	100.0%	
2.13	Are institutional level health care grievances being processed within specified time frames?	A	1	6	14.3%	+36.0
		RA	3	3	50.0%	
	Overall Percentage Score and Change:			**Annual**	**76.2%**	**-1.1**
				Re-Audit	**75.1%**	

Comments:

2.2 The facility's meeting minutes for the July and August 2018 QMC meetings had the same content as the June meeting minutes. These meeting minutes appear to have been copied from the meeting minutes for the QMC meeting conducted in June 2018.

2.4 The facility submitted a combined total of 59 weekly and monthly logs during the audit review period. Of the 59 logs submitted, 40 were received within the required time frame. Specific deficient dates of submission are listed above in the *Internal Monitoring & Quality Management* component.

2.5 The HPS auditor reviewed 17 entries within the Sick Call monitoring log for the audit review period and found 6 entries with missing/erroneous data; namely, (a) missing information on the log (one entry), (b) the "Date Seen by PCP" documented on the log does not match the date on the PCP progress note (two entries), and (c) there is no PCP progress note in the EHRS to validate the date the patient was seen (three entries).

2.6 The HPS auditor reviewed ten entries within the Specialty Care monitoring log for the audit review period and found four entries with missing/erroneous data; namely, (a) missing information in columns on the log (three entries), and (b) a patient's "CDCR Number" is incorrect (one entry).

2.7 The HPS auditor reviewed two entries within the Hospital Stay/Emergency Department/Hub Emergency Services monitoring log for the audit review period and found one entry with erroneous data, namely, the

date documented on log of patient's return to HUB after discharge from hospital/emergency department is incorrect.

2.8 The HPS auditor reviewed 17 entries within the Chronic Care monitoring log for the audit review period and found 7 entries with missing/erroneous data; namely, (a) no PCP progress note found in health record (four entries), (b) a patient's "CDCR Number" is incorrect (one entry), (c) date of "PCP Assessment" documented on log, however the patient refused the appointment and was not seen by PCP, and (d) the "Next Scheduled Appointment Date" documented on the log is three months prior to the "Actual Date of PCP Assessment" noted on the log.

2.9 The HPS auditor reviewed 20 entries within the Health Screening monitoring log for the audit review period and found 5 entries with missing/erroneous data; namely, (a) CDCR Number" is incorrect (two entries), (b) incorrect spelling of patient name (two entries), and (c) no documentation of a history and physical being completed as noted on the log (one entry).

2.13 The HPS auditor reviewed six health care grievances submitted during the audit review period and found three grievances were not completed within the specified time frame.

3. Licensing/Certifications, Training & Staffing		**Audit Type**	**Yes**	**No**	**Compliance**	**Change**
3.1	Are all health care staff licenses current?	A	12	0	100.0%	0.0
		RA	12	0	100.0%	
3.2	Are health care and custody staff current with required emergency medical response certifications?	A	78	0	100.0%	0.0
		RA	77	0	100.0%	
3.3	Does the facility provide the required training to its health care staff?	A	0	12	0.0%	0.0
		RA	0	1	0.0%	
3.4	Is there a centralized system for tracking all health care staff licenses and certifications?	A	1	0	100.0%	-100.0
		RA	0	1	0.0%	
3.5	Does the facility have the required health care and administrative staffing coverage per contractual requirement?	A	1	0	100.0%	0.0
		RA	1	0	100.0%	
3.6	Are the peer reviews of the facility's providers completed within the required time frames?	A	N/A	N/A	N/A	N/A
		RA	0	1	0.0%	
	Overall Percentage Score and Change:			**Annual**	**80.0%**	**-30.0**
				Re-Audit	**50.0%**	

Comments:

3.3 The facility did not submit a tracking log documenting health care staff training.

3.4 The facility did not provide the licensing and certification tracking log to PPCMU within the due date specified in the audit notification letter for submitting pre-audit documents.

3.6 The facility did not complete or submit the provider's four month peer review within the required time frame. The peer review was due in August 2018, however it was not submitted until October 2018.

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	16	0	100.0%	-6.2
		RA	15	1	93.8%	
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	16	0	100.0%	0.0
		RA	15	0	100.0%	
4.3	Was the focused subjective/objective assessment conducted based upon the patient's chief complaint?	A	16	0	100.0%	0.0
		RA	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
		RA	15	0	100.0%	
4.5	Did the registered nurse document that effective communication was established and education was provided to the patient related to the treatment plan?	A	16	0	100.0%	-25.0
		RA	12	4	75.0%	
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%	-2.0
		RA	8	1	88.9%	
4.7	Was the patient's chronic care follow-up visit completed as ordered?	A	14	2	87.5%	+4.8
		RA	12	1	92.3%	
4.8	Did the Care Team regularly conduct and properly document a Care Team Huddle during business days?	A	0	22	0.0%	+73.7
		RA	14	5	73.7%	
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
		RA	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	4	0	100.0%	0.0
		RA	4	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	4	0	100.0%	0.0
		RA	4	0	100.0%	
	Overall Percentage Score and Change:			**Annual**	**87.8%**	**+4.6**
				Re-Audit	**92.4%**	

Comments:

4.1 The NCPR auditor reviewed 16 electronic health records, 1 showed the patient's CDCR Form 7362 was not reviewed by the RN on the day it was received.

4.5 The NCPR auditor reviewed 16 electronic health records, 4 records did not have RN's documentation of establishing effective communication and providing education to the patients regarding their treatment plan.

4.6 The NCPR auditor reviewed nine electronic health records, 1 showed the patient referred to the PCP by the RN was not seen within the specified time frame.

4.7 The NCPR auditor reviewed 13 electronic health records, 1 showed the patient's chronic care visit was not completed as ordered.

4.8 The NCPR auditor reviewed the documentation from the Daily Care Team Huddles held during the 19 business days in September 2018. There was no documentation for one day and documentation for the remaining four days did not have all required information completed.

4.9 This question does not apply to California in-state modified community correctional facilities.

5. Diagnostic Services		**Audit Type**	**Yes**	**No**	**Compliance**	**Change**
5.1	Did the primary care provider complete a Physician's Order for each diagnostic service ordered?	A	12	0	100.0%	-6.2
		RA	15	1	93.8%	
5.2	Was the diagnostic test completed within the time frame specified by the primary care provider?	A	8	4	66.7%	+26.6
		RA	14	1	93.3%	
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	11	1	91.7%	-3.5
		RA	14	2	87.5%	
5.4	Was the patient given written notification of the diagnostic test results within two business days of receipt of results?	A	11	1	91.7%	-3.5
		RA	14	2	87.5%	
	Overall Percentage Score and Change:			**Annual**	**87.5%**	**+3.0**
				Re-Audit	**90.5%**	

Comments:

5.1 The NCPR auditor reviewed 16 electronic health records, 1 showed the PCP did not complete a Physician's Order for the diagnostic test(s) ordered.

5.2 The NCPR auditor reviewed 15 electronic health records, 1 showed the diagnostic test(s) was not completed within the time frame specified by the PCP.

5.3 The NCPR auditor reviewed 16 electronic health records, 2 showed the PCP did not review, sign, and date the patient's diagnostic test report(s) within two business days of receipt of results.

5.4 The NCPR auditor reviewed 16 electronic health records, 2 showed the patients were not given written notification of the diagnostic test results within two business days of receipt of results.

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
		RA	0	1	0.0%	
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
		RA	1	0	100.0%	
6.3	*For patients discharged from a community hospital:* Was the patient seen by the primary care provider for a follow-up appointment within five calendar days of return?	A	N/A	N/A	N/A	N/A
		RA	N/A	N/A	N/A	
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
		RA	0	1	0.0%	
	Overall Percentage Score and Change:		**Annual**		**N/A**	**N/A**
			Re-Audit		**33.3%**	

Comments:

6.1 The NCPR auditor reviewed one electronic health record and found it was missing documentation of the RN's review of the discharge plans/instructions upon the patient's return from the community hospital.

6.3 Not applicable (N/A). There were no samples found during the audit review period meeting this criteria. Therefore, this question was not rated.

6.4 The NCPR auditor reviewed one electronic health record and found the patient was not administered/delivered all his prescribed medication per policy or as ordered by the PCP.

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%	-16.7
		RA	10	2	83.3%	
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	10	0	100.0%	0.0
		RA	6	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	N/A	N/A	N/A	N/A
		RA	N/A	N/A	N/A	
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
		RA	0	1	0.0%	
7.5		A	12	0	100.0%	-16.7

	Did the patient receive a complete screening for the signs and symptoms of tuberculosis upon arrival?	RA	10	2	83.3%	
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
		RA	11	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	9	0	100.0%	-50.0
		RA	3	3	50.0%	
7.8	Does the Inter-Facility Transfer Envelope contain all the required transfer documents and medications?	A	2	1	66.7%	-33.4
		RA	1	2	33.3%	
	Overall Percentage Score and Change:			**Annual**	**94.4%**	**-30.1**
				Re-Audit	**64.3%**	

Comments:

7.1 The NCPR auditor reviewed 12 electronic health records, 2 showed the patients did not receive an initial health screening by licensed health care staff upon arrival at MFCRF.

7.3 Not applicable. None of the patients randomly selected for the sample required a referral to a provider during initial intake screening.

7.4 The NCPR auditor reviewed one electronic health record showing the patient was pending an ob-gyn appointment upon arrival, but there was no documentation the patient was seen for the appointment as scheduled.

7.5 The NCPR auditor reviewed 12 electronic health records, 2 showed the patients did not receive a complete screening for signs and symptoms of TB upon arrival.

7.7 The NCPR auditor reviewed six electronic health records, three showed when the patient transferred out of the facility, the nursing staff did not document all pending appointments on the CDCR Form 7371.

7.8 The NCPR auditor interviewed three facility RNs regarding required transfer documents and medications to be included in the Transfer Envelope prior to the patient's inter-facility transfer. Two RNs were unable to accurately describe the process or the documents/medications required to be placed in the transfer envelope.

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	2	14	12.5%	+25.0
		RA	6	10	37.5%	

8.2	If the patient refused his/her keep-on-person medications, was the refusal documented on the CDCR Form 7225, *Refusal of Examination and/or Treatment*, or similar form?	A	1	0	100.0%	N/A
		RA	N/A	N/A	N/A	
8.3	If the patient did not show or refused the nurse administered/direct observation therapy medication(s) for three consecutive days or 50 percent or more doses in a week, was the patient referred to a primary care provider?	A	N/A	N/A	N/A	N/A
		RA	N/A	N/A	N/A	
8.4	*For patients prescribed anti-Tuberculosis medication(s):* Did the facility administer the medication(s) to the patient as prescribed?	A	3	0	100.0%	-40.0
		RA	3	2	60.0%	
8.5	*For patients prescribed anti-Tuberculosis medication(s):* Did the facility monitor the patient monthly while he/she is on the medication(s)?	A	3	0	100.0%	-50.0
		RA	1	1	50.0%	
8.6	Did the prescribing primary care provider document the patient was provided education on the newly prescribed medication(s)?	A	12	0	100.0%	-33.3
		RA	8	4	66.7%	
8.7	Was the initial dose of the newly prescribed medication administered to the patient as ordered by the provider?	A	10	2	83.3%	+8.4
		RA	11	1	91.7%	
8.8	Did the nursing staff confirm the identity of a patient prior to the delivery or administration of medication(s)?	A	3	0	100.0%	0.0
		RA	2	0	100.0%	
8.9	Did the same medication nurse who administers the nurse administered/direct observation therapy medication prepare the medication just prior to administration?	A	3	0	100.0%	0.0
		RA	2	0	100.0%	
8.10	Did the medication nurse directly observe the patient taking nurse administered/direct observation therapy medication?	A	3	0	100.0%	0.0
		RA	2	0	100.0%	
8.11	Did the medication nurse document the administration of nurse administered/direct observation therapy medications on the *Medication Administration Record* once the medication was given to the patient?	AA	3	0	100.0%	0.0
		RA	2	0	100.0%	
8.12	Is nursing staff knowledgeable on the Medication Error Reporting procedure?	A	4	0	100.0%	-33.3
		RA	2	1	66.7%	
8.13	Are refrigerated drugs and vaccines stored in a separate refrigerator that does not contain food or laboratory specimens?	A	1	0	100.0%	0.0
		RA	1	0	100.0%	
8.14	Does the health care staff monitor and maintain the appropriate temperature of the refrigerators used to store drugs and vaccines twice daily?	A	61	1	98.4%	+1.6
		RA	60	0	100.0%	
8.15	Does the facility employ medication security controls over narcotic medications assigned to its clinic areas? (COCF only)	A	N/A	N/A	N/A	N/A
		RA	N/A	N/A	N/A	

8.16	Are the narcotics inventoried at every shift change by two licensed health care staff? (COCF only)	A	N/A	N/A	N/A	N/A
		RA	N/A	N/A	N/A	
8.17	Do patients, housed in Administrative Segregation Unit, have immediate access to the Short Acting Beta agonist inhalers or nitroglycerine tablets? (COCF Only)	A	N/A	N/A	N/A	N/A
		RA	N/A	N/A	N/A	
	Overall Percentage Score and Change:			**Annual**	**91.9%**	**-10.9**
				Re-Audit	**81.0%**	

Comments:

8.1 The NCPR auditor reviewed 16 electronic health records, 10 showed the patients did not receive their chronic care medication(s) within the required time frame.

8.2 N/A. None of the patients randomly selected for sample refused their keep-on-person medications.

8.3 N/A. None of the patients randomly selected for the sample did not show for or refused their nurse administered/direct observation therapy medication(s) for three consecutive days or 50 percent or more doses in a week.

8.4 The NCPR auditor reviewed five electronic health records, two showed the facility did not administer the medication(s) to the patient as prescribed.

8.5 The NCPR auditor reviewed two electronic health records, one showed the facility did not monitor the patient monthly while on anti-tuberculosis medication(s).

8.6 The NCPR auditor reviewed 12 electronic health records, 4 showed the PCP did not document the patient was provided education on newly prescribed medication(s).

8.7 The NCPR auditor reviewed 12 electronic health records, 1 showed the patient did not receive the initial dose of their newly prescribed medication as ordered by the PCP.

8.12 The NCPR auditor interviewed three RNs regarding their knowledge of the Medication Error Reporting procedure. One RN was not aware of the requirement to use the Medication Error Report Form or Health Care Incident Form.

8.15 through 8.17 These questions do not apply to California in-state facilities.

9. Observation Cells		**Audit Type**	**Yes**	**No**	**Compliance**	**Change**
9.1	Does the health care provider order patient's placement into the observation cell using the appropriate format for order entry?	A	N/A	N/A	N/A	N/A
		RA	N/A	N/A	N/A	
9.2	Does the health care provider document the need for the patient's placement in the observation cell within 24 hours of placement?	A	N/A	N/A	N/A	N/A
		RA	N/A	N/A	N/A	
9.3	Does the registered nurse complete and document an assessment on the day of a patient's assignment to the observation cell?	A	N/A	N/A	N/A	N/A
		RA	N/A	N/A	N/A	
9.4	Does the health care provider review, modify, or renew the order for suicide precaution and/or watch at least every 24 hours?	A	N/A	N/A	N/A	N/A
		RA	N/A	N/A	N/A	
9.5		A	N/A	N/A	N/A	N/A

	Does the treating clinician document daily the patient's progress toward the treatment plan goals and objectives?	RA	N/A	N/A	N/A	
9.6	Does nursing staff conduct rounds in observation unit once per watch and document the rounds in the unit log book?	A	N/A	N/A	N/A	N/A
		RA	N/A	N/A	N/A	
	Overall Percentage Score and Change:			**Annual**	**N/A**	**N/A**
				Re-Audit	**N/A**	

Comments:

9.1 through 9.6 N/A. These questions do not apply to California in-state modified community correctional facilities.

10. Specialty Services		**Audit Type**	**Yes**	**No**	**Compliance**	**Change**
10.1	Was the patient seen by the specialist for a specialty services referral within the specified time frame?	A	8	2	80.0%	+10.9
		RA	10	1	90.9%	
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	9	1	90.0%	-15.0
		RA	6	2	75.0%	
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	1	0	100.0%	-66.7
		RA	1	2	33.3%	
10.4	Did the primary care provider review the specialty consultant's report/discharge summary and complete a follow-up appointment with the patient within the required time frame?	A	5	5	50.0%	-16.7
		RA	2	4	33.3%	
	Overall Percentage Score and Change:			**Annual**	**80.0%**	**-21.9**
				Re-Audit	**58.1%**	

Comments:

10.1 The NCPR auditor reviewed 11 electronic health records, 1 showed the patient was not seen by the specialist for her specialty services referral within the specified time frame.

10.2 The NCPR auditor reviewed eight electronic health records, two showed upon patient's return from specialty service appointment, the RN did not conduct a face-to-face assessment prior to patient's return to her housing unit.

10.3 The NCPR auditor reviewed three electronic health records of patients who returned from specialty care appointments, two did not have documentation showing the RN notified the PCP of any immediate medication or follow-up requirements provided by the specialty consultant.

10.4 The NCPR auditor reviewed six electronic health records, four showed the PCP did not complete follow-up appointments with the patients within the required time frame.

11. Preventive 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	20	0	100.0%	N/A
		RA	N/A	N/A	N/A	
11.2	*For all patients:* Were patients offered an influenza vaccination for the most recent influenza season?	A	7	0	100.0%	N/A
		RA	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	2	1	66.7%	N/A
		RA	N/A	N/A	N/A	
11.4	*For female patients 50 to 74 years of age:* Were the patients offered a mammography at least every two years?	A	10	0	100.0%	N/A
		RA	N/A	N/A	N/A	
11.5	*For female patients 21 to 65 years of age:* Were the patients offered a Papanicolaou test at least every three years?	A	19	1	95.0%	N/A
		RA	N/A	N/A	N/A	
	Overall Percentage Score and Change:			**Annual**	**92.3%**	**N/A**
				Re-Audit	**N/A**	

Comments:

11.1 through 11.5 These questions are reviewed once a year during the annual audit to avoid duplication of health records reviewed.

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	3	0	100.0%	0.0
		RA	3	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	3	0	100.0%	0.0
		RA	4	0	100.0%	
12.3	Did the facility hold an Emergency Medical Response Review Committee meeting a minimum of once per month?	A	1	3	25.0%	0.0
		RA	4	0	100.0%	
12.4	Did the Emergency Medical Response Review Committee perform timely incident package reviews if they included the use of required review documents?	A	0	3	0.0%	+50.0
		RA	2	2	50.0%	

12.5	Is the facility's clinic Emergency Medical Response Bag secured with a seal?	A	93	0	100.0%	0.0
		RA	90	0	100.0%	
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	3	0	100.0%	-100.0
		RA	0	1	0.0%	
12.7	Was the Emergency Medical Response Bag inventoried at least once a month?	A	3	1	75.0%	+25.0
		RA	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	0	1	0.0%	+100.0
		RA	1	0	100.0%	
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
		RA	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
		RA	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
		RA	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
		RA	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
		RA	N/A	N/A	N/A	
12.14	Does the facility have the emergency medical equipment that is functional and operationally ready?	A	3	1	75.0%	+25.0
		RA	5	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	93	0.0%	+100.0
		RA	90	0	100.0%	
Overall Percentage Score and Change:				**Annual**	**57.5%**	**+27.5**
				Re-Audit	**85.0%**	

Comments:

12.4 The NCPR auditor reviewed the EMRRC meeting minutes for four months of the audit review period and identified the two incident packages (June 15 and July 23, 2018) did not contain all the required documents.

12.6 The NCPR auditor reviewed four emergency medical response/drill incident packages and found three did not warrant the opening of the EMR Bag. For the one incident requiring the EMR Bag, the EMR bag log did not have documentation indicating the EMR Bag was opened, resupplied, and resealed.

12.9 through 12.13 These questions do not apply to California in-state modified community correctional facilities.

13. Clinical Environment		Audit Type	Yes	No	Compliance	Change
13.1	Are packaged sterilized reusable medical instruments within the expiration dates shown on the sterile packaging?	A	0	2	0.0%	+100.0
		LR	3	0	100.0%	
13.2	If autoclave sterilization is used, is there documentation showing weekly spore testing?	A	4	0	100.0%	N/A
		LR	N/A	N/A	N/A	
13.3	Are disposable medical instruments discarded after one use into the biohazard material containers?	A	4	0	100.0%	0.0
		LR	3	0	100.0%	
13.4	Does clinical health care staff adhere to universal/standard hand hygiene precautions?	A	4	0	100.0%	-16.7
		LR	5	1	83.3%	
13.5	Is personal protective equipment readily accessible for clinical staff use?	A	1	0	100.0%	0.0
		LR	1	0	100.0%	
13.6	Is the reusable non-invasive medical equipment disinfected between each patient use when exposed to blood-borne pathogens or bodily fluids?	A	3	0	100.0%	0.0
		LR	3	0	100.0%	
13.7	Does the facility utilize a hospital grade disinfectant to clean common clinic areas with high foot traffic?	A	1	0	100.0%	0.0
		LR	1	0	100.0%	
13.8	Is environmental cleaning of common clinic areas with high foot traffic completed at least once a day?	A	31	0	100.0%	0.0
		LR	30	0	100.0%	
13.9	Is the biohazard waste bagged in a red, moisture-proof biohazard bag and stored in a labeled biohazard container in each exam room?	A	3	0	100.0%	0.0
		LR	3	0	100.0%	
13.10	Is the clinic's generated biohazard waste properly secured in the facility's central storage location that is labeled as a "biohazard" area?	A	1	0	100.0%	0.0
		LR	1	0	100.0%	
13.11	Are sharps disposed of in a puncture resistant, leak-proof container that is closeable, locked and labeled with a biohazard symbol?	A	3	0	100.0%	0.0
		LR	3	0	100.0%	
13.12	Does the facility store all sharps in a secure location?	A	1	0	100.0%	0.0
		LR	1	0	100.0%	
13.13	Does health care staff account for and reconcile all sharps at the beginning and end of each shift?	A	93	0	100.0%	0.0
		LR	90	0	100.0%	
13.14	Is the facility's biomedical equipment serviced and calibrated annually?	A	10	0	100.0%	0.0
		LR	12	0	100.0%	
13.15	Do clinic common areas and exam rooms have essential core medical equipment and supplies?	A	23	0	100.0%	0.0
		LR	3	0	100.0%	
13.16	*For Information Purposes Only (Not Scored):* Does the clinic visit location ensure the patient's visual and auditory privacy?	A	N/A	N/A	N/A	N/A
		LR	N/A	N/A	N/A	

	Overall Percentage Score and Change:	**Annual**	**93.3%**	**+5.5**
		Re-Audit	**98.8%**	

Comments:

13.2 The facility's dental clinic was not operational during the onsite audit to review the weekly spore testing report, therefore this question was not scored.

13.4 The NCPR auditor observed six nursing staff for universal/standard hand hygiene practice. One nurse did not wash or sanitize her hands between patients during sick call.

14. Quality of Nursing Performance	**Yes**	**No**	**Compliance**
The quality of nursing performance is assessed during case reviews, conducted by NCPR auditor and is not applicable for the quantitative review portion of the health care monitoring audit. The methodology used to evaluate the quality of nursing performance is presented in a separate document entitled *Private Prison Compliance and Health Care Monitoring Audit – Clinical Case Review Methodology/Guide.*	Not Applicable		

15. Quality of Provider Performance	**Yes**	**No**	**Compliance**
The quality of provider performance is assessed during case reviews, conducted by physician auditor and is not applicable for the quantitative review portion of the health care monitoring audit. The methodology used to evaluate the quality of provider performance is presented in a separate document entitled *Private Prison Compliance and Health Care Monitoring Audit – Clinical Case Review Methodology/Guide.*	Not Applicable		

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 Women's Advisory Committee (WAC) executive body and a random sample of patients housed in general population (GP) and Administrative Segregation Units (ASU). The results of the interviews conducted at MFCRF are summarized in the table below.

Although this section is not rated, audit team members made every attempt to determine with surety 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)
1. Are you aware of the sick call process?
2. Do you know how to obtain a CDCR Form 7362 or sick call form?
3. Do you know how and where to submit a completed sick call form?
4. Is assistance available if you have difficulty completing the sick call form?
5. Are you aware of the health care grievance process?
6. Do you know how to obtain a CDCR Form 602-HC, *Health Care Grievance*?
7. Do you know how and where to submit a completed health care grievance form?
8. Is assistance available if you have difficulty completing the health care grievance form?
Questions 9 through 21 are only applicable to ADA patients.
9. Are you aware of your current disability/DPP status?
10. Are you receiving any type of accommodation based on your disability? (Like housing accommodation, medical appliance, etc.)
11. Are you aware of the process to request reasonable accommodation?
12. Do you know where to obtain a reasonable accommodation request form?
13. Did you receive reasonable accommodation in a timely manner?
14. Have you used the medical appliance repair program? If yes, how long did the repair take?
15. Were you provided interim accommodation until repair was completed?
16. Are you aware of the grievance/appeal process for a disability related issue?
17. 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)?
18. Have you submitted an ADA grievance/appeal? If yes, how long did the process take?
19. Do you know who your ADA coordinator is?
20. Do you have access to licensed health care staff to address any issues regarding your disability?
21. 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 auditors interviewed four WAC members and ten patients during the onsite audit. There were no ADA patients housed at MFCRF during the onsite audit, so no ADA interviews were conducted. The auditors interviewed the members of the WAC on their overall opinion of the medical access and care provided to the patients housed at MFCRF. The WAC members brought concerns regarding care provided

to some of the patients and two of the WAC members to the attention of the physician auditor. This information has been detailed under the "*Quality of Provider Performance*" section. Additionally the WAC members stated the nursing staff do not let the patients see the PCP upon request. They are generally required to see the nurses the first two times before they are referred to the PCP. The physician auditor brought this to the attention of the HSA and management, informing them whenever feasible, the patients should be allowed to see the PCP upon their request. This will help improve the patients' confidence in the facility's health care staff and encourage them to seek medical help for their health issues and might help lower incidence of patient refusals. This will also improve their receptiveness of the treatments provided at the facility.

When the NCPR auditor interviewed the WAC members regarding access to care, medication management, specialty care services, and other health care related issues, the members expressed dissatisfaction with nursing care. It has been noted during interviews of Inmate Advisory Committees in other modified community correctional facilities, members have always expressed satisfaction with nursing care. This is one of the few facilities where patients expressed dissatisfaction with nursing care. The nature of the complaints varied from nurses' unpleasant attitude to delay in receiving care or medications. The members also complained about unhealthy and non-appetizing meals served to them.

The auditors discussed these concerns with GEO leadership and the facility management, recommending they meet with the WAC members on a regular basis to provide them a platform to discuss health care issues brought forth by the members and resolve such issues in a timely manner.

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 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 providing 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, 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 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 evaluating 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 supporting the 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 each 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 clinician auditors. The clinician 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 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 transferred into the facility and two 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 the 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 the 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 the 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%	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.