December 21, 2017

Charles Keeton, Warden
La Palma Correctional Center
5501 N La Palma Road
Eloy, AZ 85131

Dear Warden Keeton,

The staff from Private Prison Compliance and Monitoring Unit (PPCMU), Field Operations, Corrections Services, California Correctional Health Care Services (CCHCS) conducted an onsite limited review health care monitoring audit at La Palma Correctional Center (LPCC) on September 25 through 28, 2017. The purpose of this audit was to ensure that LPCC is meeting the performance targets established based on the *Receiver's Turnaround Plan of Action* dated June 8, 2006.

On December 13, 2017, a draft report was sent to your management providing the opportunity to review and dispute any findings presented in the draft. On December 19, 2017, your facility submitted a response disputing one of the audit team's quantitative findings. The attached document reflects that the quantitative item has been reconsidered and one of the three policies previously identified as deficient has been changed to compliant. This change brings your facility into compliance for that critical issue. Refer to the attached document for CCHCS's detailed response to the question disputed by LPCC.

Attached you will find the final limited review audit report which contains an explanation of the methodology behind the limited review audit and the findings of CCHCS auditors' assessment of all quality indicators (components) and processes that were identified to be deficient at the time of the previous audit conducted on January 23 through 27, 2017.

The limited review findings reveal that LPCC successfully resolved 18 of the 29 critical issues. However, of the eight critical issues reviewed remaining unresolved, two have been outstanding since the June 2015 audit, two from the February 2016 audit, and four from the January 2017 audit. There were no samples identified during the Limited Review for three critical issues and therefore compliance could not be evaluated during the Limited Review. They will be reviewed during the next audit to evaluate compliance. There were also six new critical issues identified during the September 2017 Limited Review. Five of the new critical issues were related to *Medical/Medication Management* and one qualitative issue was related to the processing of health care grievances.

While the LPCC received passing scores for all five of the quality indicators (components) which failed during the January 2017 audit, a number of minor and critical deficiencies for these indicators (components) were identified. It is concerning that LPCC received a

compliance score of 82.4% in the *Medical/Medication Management* indicator (component), however only one of the three critical issues previously identified in that indicator (component) was found resolved during the Limited Review. In addition, during the Limited Review, five new critical issues in this indicator (component) was identified. This indicator (component) is critical to the provision of adequate health care and failure to resolve these critical issues continues to impact patient care.

In addition to the deficiencies mentioned above for the *Medical/Medication Management* indicator (component), a number of minor and critical deficiencies remain unresolved or were newly identified in the following program components during the Limited Review:

- *Internal Monitoring and Quality Management*
- *Access to Care*
- *Observation Cells*
- *Specialty Services*

While the CCHCS auditors found that the overall delivery of health care at LPCC to be adequate, continued training of health care staff is needed. It is imperative that executive and health care management work together to provide training to health care staff to ensure LPCC is providing an adequate level of health care to California patients. The identified deficiencies and overall results may be included within the Federal Receiver's Tri-Annual report that is generated for the Federal Court Judge.

The deficient areas listed above can be brought to compliance by the facility's strict adherence to the established policies and procedures outlined in the *Inmate Medical Services Policies and Procedures* and the contract.

Thank you for your assistance and please extend my gratitude to your staff for their professionalism and cooperation during this audit. Should you have any questions or concerns, you may contact Rita Lowe, Health Program Manager II (A), PPCMU, Field Operations, Corrections Services, CCHCS, at (916) 691-4831 or via email at Rita.Lowe@cdcr.ca.gov.

Sincerely,

Don Meier, Deputy Director
Field Operations, Corrections Services
California Correctional Health Care Services

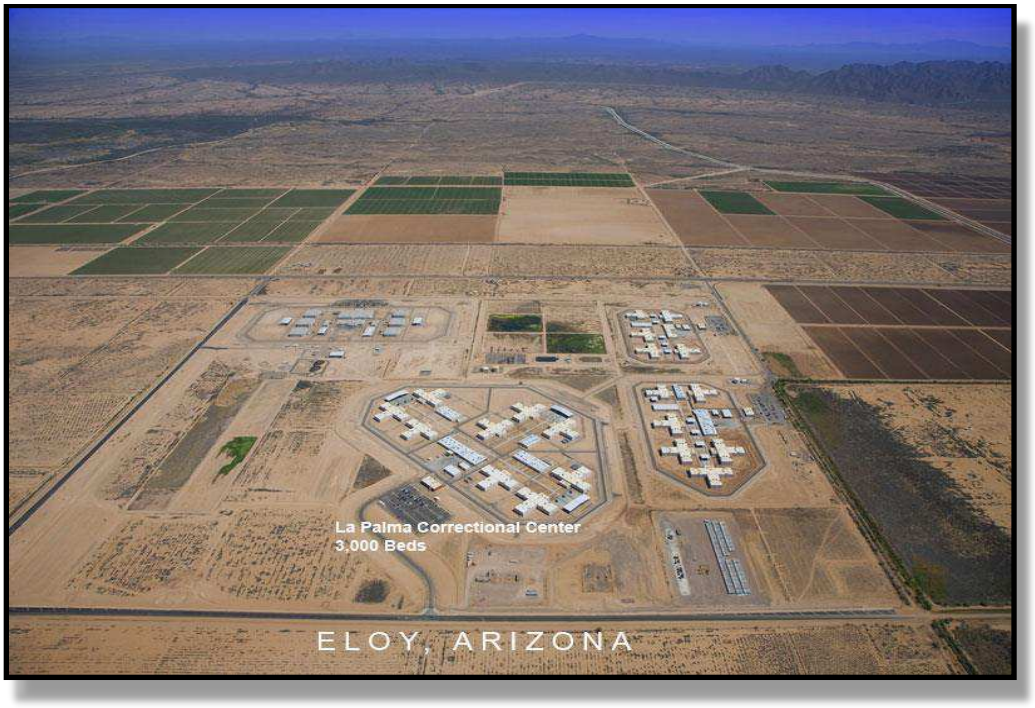
Enclosure

cc: Vincent S. Cullen, Director, Corrections Services, CCHCS
Joseph W. Moss, Chief, Contract Beds Unit (CBU), California Out of State Correctional Facility (COCF), Division of Adult Institutions (DAI), California Department of Corrections and Rehabilitation (CDCR)
Damon Huser, Correctional Administrator, CBU, COCF, DAI, CDCR
Keith Ivens, MD, Chief Medical Officer, CoreCivic
William Crane, MD, Regional Medical Director, CoreCivic
Judy Burleson, Correctional Administrator, Field Operations, Corrections Services, CCHCS
Rita Lowe, Health Program Manager II (A), PPCMU, Field Operations, Corrections Services, CCHCS

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

CONTRACT FACILITY HEALTH CARE MONITORING AUDIT

Limited Review



La Palma Correctional Center

September 25-28, 2017

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INTRODUCTION

As a result of an increasing inmate population and a limited capacity to house inmates, the California Department of Corrections and Rehabilitation (CDCR) entered into contractual agreements with private prison vendors to house California inmates. Although these inmates are housed in a contracted facility, either in or out-of-state, the California Correctional Health Care Services (CCHCS) is responsible to ensure health care standards equivalent to California's regulations, CCHCS's policy and procedure, and court ordered mandates are provided.

As one of several means to ensure the prescribed health care standards are provided, CCHCS staff developed a tool to evaluate and monitor the delivery of health care services provided at the contracted facility through a standardized audit process. This process consists of a review of various documents obtained from the facility; including medical records, monitoring reports, staffing rosters, Disability Placement Program list, and other relevant health care documents, as well as an onsite assessment involving staff and patient interviews and a tour of all health care service points within the facility.

This report provides the findings associated with the Limited Review conducted on September 25 through 28, 2017 at La Palma Correctional Center (LPCC), which is located in Eloy, Arizona. Based on the CDCR's *Weekly Population Count* report, dated September 29, 2017, at the time of the onsite Limited Review audit LPCC's patient population was 3,108, with a budgeted capacity of 3,146.

Audit Review

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 and the out-of-state correctional facilities (COCF) currently in contract with California. During the first six months of the calendar year, the PPCMU audit team will conduct a full audit on all the facilities using the revised Audit Guide 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, either a full review or 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.

Type of Audit Review

The following guidelines will be used in the determination of the type of review to be performed:

- If the facility achieved an overall audit rating of "**Proficient**" (≥ 90%) on the first round of audit, the facility **may** undergo a second round of audit in the same calendar year.

- If the facility achieved an overall audit rating of "**Adequate**" (80.0 - 89.9%), a ***Limited Review*** will be conducted during the second half of the calendar year.
- If the facility achieved an overall audit rating of "**Inadequate**" (<80.0%), a second ***full*** review will be conducted during the second half of the calendar year.

Limited Review

For a Limited Review, the following guidelines will be followed:

- If the overall rating for a specific quality indicator (component), e.g., Access to Care, is "**Inadequate**," the CCHCS auditors will perform a review of all sections pertaining to the inadequate indicator (component). The auditors will perform nursing case review, physician case review, and quantitative review which is comprised of onsite and electronic medical record review.
- If the overall rating for a specific quality indicator (component) is "**Adequate**," the CCHCS auditors will only perform a review of those sections that scored less than 80%. For example, if the Diagnostic Services overall score of 85.0% resulted from the following review scores: physician case review of 70.0%; nursing case review of 90.0%, and the quantitative review of 95.0%, then the only review to be performed is the physician case review and review of any quantitative critical issues identified in the previous audit.
- For the quantitative review portion, if the score of a specific quality indicator (component) is equal to or above 80.0%, the CCHCS auditors will only review critical issues identified during the previous audit or specific questions scoring below 80.0% under that specific (component).
- The quality indicators (components) "Quality of Nursing Performance" and "Quality of Provider Performance" will be excluded under the Limited Review. CCHCS clinicians will only review patient encounters occurring during the four-month Limited Review audit period that pertain to failed sections for all other quality indicators (components).

Limited Review Sample Size

For sample selection on case reviews, the CCHCS nurse auditor will select a sample of 10 patients that will likely have frequent encounters related to the quality indicator (component) being reviewed. Due to less frequent physician-patient encounters in a month, the CCHCS physician auditor will review a total of 15 patients to obtain sufficient data.

Review Period

The CCHCS auditors will utilize four months of data for both full and Limited Reviews to avoid the overlapping of months previously audited.

During the September 2017 Limited Review process for the audit review period of May 1 through August 31, 2017, the auditors conducted an assessment of all quality indicators (components) and processes that were identified to be deficient at the time of the previous audit conducted at LPCC on January 23 through 27, 2017. The deficient items included findings obtained from medical record reviews, pre-audit document reviews, clinician case reviews, and onsite observations and interviews. During all

Limited Reviews the auditors utilize the same methodology initially used in the previous full audit to determine compliance with a specific standard/requirement maintaining consistency during each review.

METHODOLOGY

The auditors predominantly utilize three methods to evaluate compliance during the review process:

i. Medical Record Review: All items that were previously found to be deficient following the health record reviews are evaluated by the clinician auditors. The nurse and physician auditors review a sample of patient health records as identified in the Audit Guide methodology (Rev. September 2016) for a four month audit review period. For limited case reviews, the nurse auditor reviews 10 cases while the physician reviews 15 cases. Under each quality indicator (component), questions that previously did not meet the 80% compliance standard will be separately reviewed by a nurse auditor. Compliance is determined based on the documentation found in the medical records and not in the shadow files kept by the facility. This review is completed remotely by reviewing the electronic medical record. The issues are determined to be resolved only if the quality indicators (components) or the questions under each indicator (component) score above the 80% compliance threshold.

ii. Document Review: The administrative items that were previously identified to be deficient related to the facility's lack of policies and procedures, absence of training logs, absence of mechanism to track the release of information, health care grievances/appeals, licenses and certifications, and contracts are evaluated by the Health Program Specialists I (HPS I). The facilities are requested to submit the pertinent documentation to PPCMU prior to the onsite review. The HPS I auditors review the documents received from the facility and determine compliance.

iii. Onsite observation and interviews with LPCC health care staff: The critical issues previously identified resulting from onsite inspections and observations of facility's various medical processes and staff interviews are evaluated during the onsite visit. The nurse and HPS I auditors conduct inspections of various clinical and housing areas within the facility, interview key facility personnel, which includes medical and custody staff, for the overall purpose of evaluating compliance of the identified critical issues and to identify any new issues.

EXECUTIVE SUMMARY

A full health care monitoring audit was conducted at LPCC on January 23 through 27, 2017. The review period for the January 2017 audit was June 1, 2016 through November 30, 2016. The facility received an overall compliance rating of *Adequate* (84.1%).

On September 25 through 28, 2017, the PPCMU audit team conducted a four month Limited Review at LPCC to assess the failed components and critical issues identified during the January 2017 audit. The Limited Review period was May 1, 2017 through August 31, 2017. The audit team consisted of the following personnel:

R. Delgado, Medical Doctor, Retired Annuitant
L. Pareja, Nurse Consultant, Program Review
S. Thomas, Health Program Specialist I

The scope of the review included:

- Re-examination of all sections (clinical case reviews, medical record review, and onsite review) of the *Administrative Operations, Internal Monitoring and Quality Management, Licensing/Certifications, Training and Staffing, Medical/Medication Management*, and *Observation Cells* indicators (components);
- Review of all quantitative and qualitative critical issues of the *Access to Care*, *Diagnostic Services*, *Specialty Services, Emergency Services and Community Hospital Discharge, and Clinical Environment* indicators (components);
- Physician case review for the *Access to Care* indicator (component);

The critical issue identified in the *Preventative Services* indicator (component) during the January 2017 audit was not evaluated during the Limited Review as it is reviewed annually during the full audits completed during the months of January through June each year. This critical issue will be evaluated during the next full health care audit to determine compliance.

The results of the Limited Review revealed that LPCC received three *proficient* and two *adequate* ratings for the five quality indicators (components) which had received *inadequate* ratings during the January 2017 audit. The comparison of the overall quality indicator compliance scores for these five indicators (components) are shown in Table 1.1.

Table 1.1

	Quality Indicator (Component) Full Review	January 2017 Overall Indicator (Component) Compliance Score	September 2017 Overall Indicator (Component) Compliance Score
1.	Administrative Operations	72.1%	96.8%
2.	Internal Monitoring and Quality Management	73.7%	94.0%
3.	Licensing/Certifications, Training and Staffing	77.8%	83.3%
8.	Medical/Medication Management	74.6%	82.4%
9.	Observation Cells	72.7%	91.5%

The CCHCS auditors also reviewed the 29 critical issues identified during the January 2017 audit. The facility successfully resolved 18 out of 29 critical issues as indicated in Table 1.2. However, there were six new critical issues identified during the current review in the *Medical/Medication Management* and *Internal Monitoring and Quality Management* indicators (components).

Table 1.2

Quality Indicators (Components) Limited Review		Previous Critical Issues	Resolved	Unresolved	New Critical Issues Limited Review	Current Critical Issues
1.	Administrative Operations	4	4	0	0	0
2.	Internal Monitoring and Quality Management	8	6	2	0	2
3.	Licensing/Certifications, Training and Staffing	2	1	1	0	1
4.	Access to Care	2	1	1	0	1
5.	Diagnostic Services	1	1	0	0	0
8.	Medical/Medication Management	3	1	2	5	7
9.	Observation Cells	3	0	3	0	3
10.	Specialty Services	1	0	1	0	1
11.	Preventative Services	1	0	1	0	1
12.	Emergency Medical Response/Drills and Equipment	1	1	0	0	0
13.	Clinical Environment	1	1	0	0	0
	Qualitative Critical Issue	2	2	0	1	1
	Totals:	**29**	**18**	**11**	**6**	**17**

A discussion of the facility's progress toward resolution of all Critical Issue items identified during the previous audit is included in the Critical Issue Review section on page 27 of this report.

IDENTIFICATION OF CRITICAL ISSUES

The table below reflects the 11 unresolved critical issues along with the six new critical issues identified during the current Limited Review in which the facility's compliance remained or fell below acceptable compliance levels during the review.

Critical Issues – La Palma Correctional Center	
Question 2.5	The facility does not accurately document all the dates on the sick call monitoring log. ***This deficiency has been outstanding since the June 2015 audit.***
Question 2.13	The first level health care grievances/appeals are not being processed within the specified time frames. ***This deficiency has been outstanding since the February 2016 audit.***
Question 3.5	The facility does not have the required health care staff complement. ***This deficiency has been outstanding since the February 2016 audit*.**
Question 4.8	The facility health care staff does not consistently conduct/document daily care team huddles. ***This is an unresolved issue from the January 2017 audit.***
Question 8.1	Chronic care medications are not consistently received by the patient within the required time frame. ***This deficiency has been outstanding since the June 2015 audit.***
Question 8.3	The nursing staff do not consistently refer the patients to the provider when they do not show or refuse the nurse administered/direct observation therapy medications (NA/DOT) for three consecutive days or 50 percent or more doses in a week. There were no qualifying samples identified for this question, therefore it could not be evaluated during the Limited Review. ***This deficiency has been outstanding since the June 2015 audit.***
Question 8.5	The facility failed to administer anti-tuberculosis medications to patients as prescribed. ***This is a new critical issue.***
Question 8.7	Primary Care Physician (PCP) staff failed to document that the patient was provided education on newly prescribed medication(s). ***This is a new critical issue.***
Question 8.8	The facility health care staff failed to administer the initial dose of newly prescribed medication to the patient as ordered by the provider. ***This is a new critical issue.***
Question 8.11	The nursing staff failed to directly observe the patient taking NA/DOT medication. ***This is a new critical issue.***
Question 8.18	The facility failed to ensure patients housed in the administrative segregation unit who are prescribed short acting beta agonist inhalers or nitroglycerin tablets have them on their person (in their cells). ***This is a new critical issue.***
Question 9.2	The facility providers are not documenting the need for the patient's placement in the observation cell within 24 hours of placement. ***This is an unresolved issue from the January 2017 audit.***

Question 9.5	The treating clinician does not document daily the patient's progress toward the treatment plan goals and objectives for patients housed in observation cell for suicide precaution and/or watch. There were no patients housed in an observation cell on suicide watch during the audit review period, therefore this question could not be evaluated during the Limited Review. ***This remains an unresolved issue from the January 2017 audit.***
Question 9.6	The nursing staff is not consistently documenting their daily rounds once per watch in the unit log book when a patient is housed in the observation unit. ***This is an unresolved issue from the January 2017 audit.***
Question 10.3	The Registered Nurse does not consistently notify the provider of any immediate orders or follow-up instructions provided by the specialty care consultant. ***This deficiency has been outstanding since the June 2015 audit.***
Question 11.3	The facility does not consistently offer colorectal cancer screening to the patient population 50-75 years of age. This question is reviewed annually to avoid duplication of selection from the sample population and will be reviewed during subsequent audits to monitor compliance. ***This remains an unresolved issue from the January 2017 audit.***
Qualitative Critical Issue #1	Health care grievances/appeals were received and screened by non-health care staff. ***This is a new critical issue.***

These deficiencies will require the facility to take the necessary action to bring the deficiency into compliance and will be re-examined during the facility's next scheduled health care audit.

AUDIT FINDINGS – DETAILED BY QUALITY INDICATOR (COMPONENT)

1 - ADMINISTRATIVE OPERATIONS

Quantitative Review Results

During the January 2017 audit, the facility received a compliance score of 72.1% (*inadequate*) in the *Administrative Operations indicator (component)* with four critical issues identified. During the current Limited Review, the four critical issues were found to be resolved. During the current Limited Review, one Local Operating Procedure (LOP) (Chronic Care) was scored as not applicable (N/A) as the corresponding policy in the IMSP&P was removed. The remaining non-compliant LOPs are as follows:

- The facility's Access to Care policy failed to document the requirements for holding and documenting daily care huddles per IMSP&P.
- The facility's Health Care Transfer policy failed to list all the documents required to be placed in the patient's transfer envelope.

Administrative Operations		**January 2017 Audit Score**	**September 2017 Limited Review Audit Score**	**Change**
1.1	Does health care staff have access to the facility's health care policies and procedures and know how to access them?	60.0%	100%	40.0
1.2	Does the facility have written health care policies and local operating procedures that are in compliance with *Inmate Medical Services Policies and Procedures* guidelines?	57.1%	84.6%	27.5
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?	100%	100%	0.0
1.4	Does the patient orientation handbook/manual or similar document explain the sick call and health care grievance/appeal processes?	0.0%	100%	100
1.5	Does the facility's provider(s) access the California Correctional Health Care Services patient electronic medical record system regularly?	100%	100%	0.0
1.6	Does the facility maintain a Release of Information log that contains all the required data fields?	100%	100%	0.0
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?	60.0%	90.0%	30.0
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?	100%	100%	0.0
	Overall Percentage Score and Change:	**72.1%**	**96.8%**	**24.7**

Comments:

1.2 The facility's health care policies and local operating procedures are not all in compliance with the IMSP&P guidelines. *This critical issue has been resolved by the facility*.

1.7 The CCHCS auditor reviewed 20 patients' requests for copies of medical records submitted during the Limited Review period. Eighteen records had documentation that the patient received his medical records within the required time frame. The dates documented on the Release of Information Log showed that two patients failed to receive their records within the 15 business day time frame, resulting in 90.0% compliance. This is an improvement from the 60.0% compliance score received during the January 2017 audit. *This critical issue has been resolved by the facility.*

Details regarding the resolution of the facility's other two critical issues which were previously identified for this indicator (component), can be found in the Critical Issue Review section located on page 27 of this report.

Recommendations:

- Hold regularly scheduled meetings among nursing supervisors to discuss commonly used, revised, and new IMSP&P policies and procedures to plan health care staff training and implementation.

2 – INTERNAL MONITORING AND QUALITY MANAGEMENT

Quantitative Review Results

During the January 2017 audit, LPCC received an overall quality indicator (component) score of 73.7% (*inadequate)* for *Internal Monitoring and Quality Management* with eight critical issues identified. During the September 2017 Limited Review, LPCC received a score of 94.3% (*proficient*) with six of the eight critical issues resolved and two remaining deficient.

One deficiency is related to the Sick Call monitoring log. This log remained non-compliant during the Limited Review having received a score of 78.9%. Thirty eight entries on the log were reviewed with eight documentation errors identified. The errors identified are listed below:

- Three entries failed to document the correct date the patient was seen by the registered nurse (RN).
- Two records reviewed for two entries failed to have documentation of the patient having been seen by RN, or a signed refusal form to validate the entries on the log.
- Two entries failed to have the date seen by the PCP documented on the log.
- One entry's date of the RN face to face assessment documented on the log did not match the date of the documentation found in the patient's medical record.

The second unresolved critical issue is regarding the processing of first level health care grievances/appeals which has been an outstanding deficiency since the February 2016 audit. During the two prior audits (February 2016 and January 2017) and the current Limited Review, the facility's grievance/appeal tracking log was found to have numerous errors. The CCHCS auditor reviewed the facility's grievance/appeal log which documented 84 grievances/appeals were processed during the review period (May 1 through August 31, 2017). Twenty-three grievances/appeals reviewed were not scored as they were withdrawn by the patient within the required time frame or they were not health

care related. Of the 61 qualifying grievances/appeals, 38 were processed within the required time frame. There were discrepancies of the dates the grievances/appeals were delivered to the patient noted on the grievance/appeal log compared to the dates documented on the grievance/appeal forms. Numerous grievances/appeals were rejected in error, and others had a large amount of duplicate paperwork provided by the facility.

A new critical issue was identified due to health care grievances/appeals being received and screened by the facility's Grievance Office. This is a violation of the *Health Insurance Portability and Accountability Act*[1] (HIPAA) and the CDCR CCHCS requirement for health care grievances/appeals to be screened and responded to by health care staff. The grievance/appeal processing deficiencies identified during the Limited Review are as follows:

- Eleven grievances/appeals were rejected due to the patients not attaching a sick call slip.
    - Sick call slips are not required to be attached to the health care grievance/appeal by the patient upon submission of the appeal form.
- Four were rejected due to the patients' failure to submit a CDCR Form 22, *Inmate/Parolee Request for Interview, Item or Service*.
    - Patients are not required to submit a CDCR Form 22 prior to submitting a health care grievance/appeal for response.
- Two were rejected and the patients were instructed to submit a sick call slip to the medical department before filing a health care grievance/appeal.
    - One rejection letter instructed the patient, when resubmitting the grievance/appeal, to submit a CDCR Form 602, *Inmate/Parolee Appeal*, instead of a CDCR Form 602 HC, *Patient-Inmate Health Care Appeal*, possibly resulting in the grievance/appeal being rejected for use of the incorrect form.
- One grievance/appeal was rejected when the patient arrived to LPCC from Tallahatchie County Correctional Facility (TCCF) without his eye glasses.
    - The grievance/appeal was rejected and forwarded to TCCF rather than staff contacting TCCF in an attempt to locate the missing glasses.
- Two grievance/appeal responses were completed but were not delivered to the patients within the required time frame.
- Three grievances/appeals were noted on the log, however no documentation was submitted to the CCHCS auditor for review.
- Health care grievances/appeals are required to be screened by health care staff, however, the grievances/appeals were screened by non-health care staff working in the facility's Grievance Office.

[1] HIPAA - United States legislation that provides data privacy and security provisions for safeguarding medical information.

Internal Monitoring & Quality Management		January 2017 Audit Score	September 2017 Limited Review Audit Score	Change
2.1	Did the facility hold a Quality Management Committee meeting a minimum of once per month?	100%	100%	0.0
2.2	Did the Quality Management Committee's review process include documented corrective action plan for the identified opportunities for improvement?	33.3%	100%	66.7
2.3	Did the Quality Management Committee's review process include monitoring of defined aspects of care?	100%	100%	0.0
2.4	Did the facility submit the required monitoring logs by the scheduled date per Private Prison Compliance and Monitoring Unit program standards?	100%	96.2%	<3.8>
2.5	Is data documented on the sick call monitoring log accurate?	46.3%	78.9%	32.6
2.6	Is data documented on the specialty care monitoring log accurate?	72.5%	97.0%	24.7
2.7	Is data documented on the hospital stay/emergency department monitoring log accurate?	73.0%	96.4%	23.4
2.8	Is data documented on the chronic care monitoring log accurate?	78.3%	95.0%	16.7
2.9	Is data documented on the initial intake screening monitoring log accurate?	71.7%	100%	28.3
2.10	Are the CDCR Forms 602-HC, *Patient-Inmate Health Care Appeals,* readily available to patients in all housing units?	11.1%	100%	88.9
2.11	Are patients able to submit the CDCR Forms 602-HC, *Patient-Inmate Health Care Appeals,* on a daily basis in all housing units?	100%	100%	0.0
2.12	Does the facility maintain a Health Care Appeals log that contains all the required information?	100%	100%	0.0
2.13	Are the first level health care appeals being processed within specified time frames?	72.4%	62.3%	<10.1>
	Overall Percentage Score and Change:	**73.7%**	**94.3%**	**20.6**

Comments:

2.4 The facility failed to submit their monthly monitoring logs on time during the month of May 2017. The Chronic Care and Initial Intake Screening logs were due on May 5, 2017, but were not received until May 8, 2017.

2.5 During the Limited Review, 38 entries on the sick call monitoring log for the audit review period were reviewed for accuracy. Eight of the entries were found to be inaccurate, resulting in a 78.9% compliance score. *This critical issue remains unresolved and will be monitored during subsequent audits for compliance.*

2.6 Thirty three entries on the specialty services monitoring log were reviewed of patients receiving specialty services during the Limited Review audit period. On one record, there was no documentation in the medical record of the PCP referring the patient for a colonoscopy. *This critical issue has been resolved by the facility.*

2.7 Twenty-eight entries on the hospital stay/emergency department monitoring log were reviewed of patients requiring emergency services during the Limited Review period. For one record, the PCP assessment date noted on the log (June 15, 2017) does not match the date (June 14, 2017) of the PCP's progress note in the medical record. *This critical issue has been resolved by the facility.*

2.8 Forty entries for the chronic care monitoring log were reviewed by the CCHCS auditor for patients being seen in the chronic care clinic during the review period. Two of the entries were found to have inaccurate data. One entry's actual date of PCP assessment in the medical record does not match the date documented on the log. The other entry documented the incorrect chronic care clinic. *This critical issue has been resolved by the facility.*

2.13 The CCHCS auditor reviewed 61 first level health care grievances/appeals which were processed by the facility during the audit review period. Twenty-three of the grievances/appeals were not processed within the required time frame or were inappropriately screened out. *This critical issue remains unresolved and will be monitored during subsequent audits for compliance.*

Details regarding the resolution of the six critical issues can be found in the Critical Issue Review section located on page 27 of this report.

As of September 1, 2017, CDCR/CCHCS has revised the health care grievance/appeal process. The CCHCS auditor discussed the revised *Health Care Grievance Regulations* and processing of the health care grievances/appeals with the facility's Health Services Administrator (HSA) during the onsite audit. The CCHCS auditor discussed the various concerns regarding the health care grievances/appeals with the HSA. Grievances/appeals were being received and screened by the non-health care staff working in the facility's Grievance Office and numerous grievances/appeals were erroneously rejected during the Limited Review period. The HSA reported that the facility is in the process of re-labeling the locked sick call/medical boxes to include the words "health care grievances". The patients will then be advised to submit the health care grievances/appeals in the locked sick call/grievance box. The HSA also reported that as of September 1, 2017, a RN is screening all health care grievances/appeals within one business day of receipt and that health care grievances/appeals are no longer being rejected due to the patient failing to attach a sick call receipt or CDCR Form 22.

3 – LICENSING/CERTIFICATIONS, TRAINING, AND STAFFING

Quantitative Review Results

LPCC received an overall quality indicator (component) rating of i*nadequate* (77.8%) for *Licensing/Certifications, Training and Staffing* during the January 2017 audit with two critical issues identified. During the current Limited Review, LPCC achieved an overall quality indicator (component) rating of *Adequate* (83.3%). LPCC was successful in resolving one of the critical issues, however the facility remains non-compliant with having the required health care staffing complement.

Licensing/Certifications, Training and Staffing		January 2017 Audit Score	September 2017 Limited Review Audit Score	Change
3.1	Are all health care staff licenses current?	100%	100%	0.0
3.2	Are health care and custody staff current with required medical emergency response certifications?	100%	100%	0.0
3.3	Does the facility provide the required training to its health care staff?	100%	100%	0.0
3.4	Is there a centralized system for tracking all health care staff licenses and certifications?	100%	100%	0.0
3.5	Does the facility have the required health care and administrative staffing coverage per contractual requirement?	0.0%	0.0%	0.0
3.6	Are the peer reviews of the facility's providers completed within the required time frames?	66.7%	100%	33.3
	Overall Percentage Score and Change:	**77.8%**	**83.3%**	**5.5**

Comments:

3.5 LPCC continues to have vacant medical positions; two licensed practical nurses, one RN, and one medical record clerk. *This critical issue remains unresolved and will be monitored during subsequent audits for compliance.*

4 - ACCESS TO CARE

During the September 2017 Limited Review, physician case reviews and evaluation of the two critical issues identified during the January 2017 audit for *Access to Care* were completed. The facility was successful in the resolution of one critical issue (Refer to Table 1.2 on page 7). The findings related to the review of the physician case reviews and the two critical issues for this indicator (component) are documented below.

Audit Date	NCPR Compliance Score	Provider Compliance Score	Quantitative Score
January 2017	86.5%	75.0%	83.6%
Limited Review September 2017	N/A	95.5%	N/A

Quantitative Review Results

The remaining critical issue is regarding the daily care huddles being completed in the three medical compounds at LPCC. The CCHCS nurse auditor reviewed the daily care huddles for all three medical compounds[2] for the 23 business days during the month of August 2017. Compound 2 was found

[2] Medical compound – LPCC has three housing compounds (units). Each compound has a medical clinic which provides medical services to the patient population housed in that compound.

to be proficient in their documentation, receiving 100% compliance. The deficiencies for Compounds 1 and 3 are as follows:

- **Compound 1**: Documentation for seven days of the 23 days reviewed was adequate. However, the documentation for the other 15 days noted lab issues and expiring meds, but no plan of action was documented to address those issues. One day, August 10, 2017, the facility failed to provide daily care huddle documentation.
- **Compound 3**: Documentation for 11 of the 23 days reviewed was adequate. However, there was no daily care huddle documentation received for five days. Seven days failed to have a plan of action for new patients and patients returning from a higher level of care such as: "What needs to be done, any preparation? Who needs to be referred to the PCP?" For patients returning from higher level of care, "What action is anticipated? What preparation is needed? What needs to be observed?"

Access to Care		**January 2017 Audit Score**	**September 2017 Limited Review Audit Score**	**Change**
4.8	Did the Care Team regularly conduct and document a Care Team Huddle during business days?	15.2%	37.3%	22.1
4.10	Are the CDCR Forms 7362, *Health Care Services Request,* or similar form, readily accessible to patients in all housing units?	11.1%	100%	88.9

Comments:

4.8 Compounds 1 and 3 failed to consistently conduct and adequately document daily care team huddles, while Compound 2 was 100% compliant as documented above. *This critical issue remains unresolved and will be monitored during subsequent audits for compliance.*

Case Review Results

Physician

The CCHCS physician auditor reviewed 22 encounters and identified one deficiency resulting in a *proficient* (95.5%) rating. The deficiency identified by CCHCS physician auditor is as follows:

- In Case 15, the patient was seen by the mid-level provider for symptoms of acid reflux (heartburn) and prescribed medication. The patient was seen by the RN for follow-up of continued reflux symptoms. The mid-level provider prescribed a six month supply of the medication, but did not schedule a follow-up appointment. The patient should have been scheduled to be seen by the PCP for follow-up.

Recommendations:

- Continue health care staff training on the required procedures and documentation regarding daily care huddles.
- Continue weekly provider meetings to discuss interesting and challenging cases and to foster continued camaraderie. Document the meetings and briefly address the content and attendance.
- On call providers to maintain a telephone call log to memorialize phone calls with other providers and institutions. Brief notes summarizing phone calls should be scanned into the medical record on a regular basis.
- Continue to improve upon patient refusal notes; providers should generate a personalized note documenting potential risks of the refusal that were discussed with the patient along with the refusal form.
- Provide medical services at a level as directed by the California Title 15; provide only services that are medically necessary.
- Tests of Adult Basic Education (TABE)[3] scores should be listed in the "FYI" section in the demographic portion of the electronic medical record.

5 – DIAGNOSTIC SERVICES

Quantitative Review Results

One critical issue from the January 2017 audit for the *Diagnostic Services* Indicator (component) was reviewed during the Limited Review. This critical issue had been deficient since the June 2015 audit and was found to be resolved during the Limited Review.

Diagnostic Services		**January 2017 Audit Score**	**September 2017 Limited Review Audit Score**	**Change**
5.4	Was the patient given written notification of the diagnostic test results within two business days of receipt of results?	55.6%	81.8%	26.3

Comments:

5.4 The CCHCS nurse auditor reviewed 11 medical records of patients who had diagnostic tests completed during the audit review period. Nine were found to contain documentation that the patient was given notification of his diagnostic test results within the required time frame and two failed to have documentation. The facility received a compliance score of 81.8% during the September 2017 Limited Review. This is an improvement from the 55.6% compliance score received during the January 2017 audit. *The facility has resolved this critical issue.*

[3] TABE - a standardized, multiple-choice test designed to assess basic reading, mathematics, and language skills. Patients whose TABE scores are less than or equal to 4.0 require effective communication to be established during all health care encounters.

8 - MEDICAL/MEDICATION MANAGEMENT

The facility received an overall quality indicator (component) score of 74.6% (*inadequate*) in *Medical/Medication Management* during the January 2017 audit with three critical issues identified. During the September Limited Review, all sections, clinician case reviews, medical record review, and quantitative reviews, of this indicator (component) were evaluated. One of the three critical issues was resolved and two remain unresolved (Refer to Table 1.2 on page 7). Of the two unresolved critical issues, one was not evaluated as there were no samples identified meeting the criteria for the question during the Limited Review. In addition, there were five new critical issues identified within the Medical/Medication Management indicator (component), during the Limited Review. Specific findings related to the clinician case reviews and critical issues identified are documented below.

Audit Date	NCPR Compliance Score	Provider Compliance Score	Quantitative Score
January 2017	56.5%	85.4%	82.0%
Limited Review September 2017	74.1%	92.3%	83.2%

Quantitative Review Results

The facility failed to provide patients with their chronic care medication within the required timeframe.

There were no medical records identified meeting the criteria of patient's requiring a PCP referral for failing to show or refusing the NA/DOT medications for three consecutive days or 50 percent or more doses in a week during the Limited Review period. Therefore, this critical issue could not be evaluated and is considered unresolved and will be reviewed during the next audit to determine compliance.

Medical/Medication Management		**January 2017 Audit Score**	**September 2017 Limited Review Audit Score**	**Change**
8.1	Were the patient's chronic care medications received by the patient within the required time frame?	45.8%	6.3%	<39.5>
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?	N/A	100%	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?	0.0%	N/A	N/A
8.4	If the patient missed or refused one dose of a critical medication, was the patient referred and seen by the licensed health care staff within 24 hours following the referral?	N/A	N/A	N/A

8.5	*For patients prescribed anti-Tuberculosis medication(s):* Did the facility administer the medication(s) to the patient as prescribed?	100%	71.4%	<28.6>
8.6	*For patients prescribed anti-Tuberculosis medication(s):* Did the facility monitor the patient monthly while he/she is on the medication(s)?	100%	100%	0.0
8.7	Did the prescribing primary care provider document that the patient was provided education on the newly prescribed medication(s)?	91.3%	75.0%	<16.3>
8.8	Was the initial dose of the newly prescribed medication administered to the patient as ordered by the provider?	95.7%	58.3%	<37.4>
8.9	Did the nursing staff confirm the identity of a patient prior to the delivery or administration of medication(s)?	100%	100%	0.0%
8.10	Did the same medication nurse who administers the nurse administered/direct observation therapy medication prepare the medication just prior to administration?	100%	100%	0.0
8.11	Did the medication nurse directly observe the patient taking nurse administered/direct observation therapy medication?	100%	71.4%	<30.6>
8.12	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?	80.0%	100%	20.0
8.13	Is nursing staff knowledgeable on the Medication Error Reporting procedure?	0.0%	100%	100
8.14	Are refrigerated drugs and vaccines stored in a separate refrigerator that does not contain food or laboratory specimens?	100%	100%	0.0
8.15	Does the health care staff monitor and maintain the appropriate temperature of the refrigerators used to store drugs and vaccines twice daily?	100%	100%	0.0
8.16	Does the facility employ medication security controls over narcotic medications assigned to its clinic areas? (COCF only)	100%	100%	0.0
8.17	Are the narcotics inventoried at every shift change by two licensed health care staff? (COCF only)	100%	92.5%	<7.5>
8.18	Do patients, housed in Administrative Segregation Unit, have immediate access to the Short Acting Beta agonist inhalers or nitroglycerine tablets? (COCF Only)	100%	16.7%	<83.3>
	Overall Percentage Score and Change:	**82.0%**	**80.7%**	**1.3**

Comments:

8.1 Sixteen medical records were reviewed with only one record having documentation that the patient received his chronic care medications within the required timeframe during the audit review period. The facility received a 6.3% compliance score during the Limited Review, which is a decrease of 39.5 percentage points from the January 2017 audit. *This critical issue remains unresolved and will be monitored during subsequent audits for compliance.*

8.3 N/A During the Limited Review period, there were no patients identified who missed or refused NA/DOT medications for three consecutive days or 50 percent or more times in a week requiring to be referred to the PCP. Therefore, *this critical issue could not be evaluated and remains unresolved and will be monitored during subsequent audits for compliance.*

8.4 N/A There were no patients identified who missed or refused one dose of critical medications requiring referral to the PCP, during the Limited Review period.

8.5 Seven medical records were reviewed for this question. Five of the seven records had documentation that the facility administered the patient's anti-TB medication(s) to the patient as prescribed, resulting in a 71.4% compliance Score. This is a 28.6% point decrease in compliance from the January 2017 audit. *This is a new critical issue.*

8.7 Twelve medical records were reviewed. Nine records reflect that the prescribing PCP documented that the patient was provided education on the newly prescribed medication(s), resulting in a 75.0% compliance Score. This is a 16.3% decrease in compliance from the January 2017 audit. *This is a new critical issue.*

8.8 Seven of the 12 medical records reviewed had documentation that the patient's initial dose of the newly prescribed medication was administered to the patient as ordered by the provider, resulting in a 58.3% compliance score. This is a 37.4% decrease in compliance from the January 2017 audit. *This is a new critical issue.*

8.11 Seven nurses were observed performing NA/DOT medication administration. Five of the seven nurses properly observed the patient taking NA/DOT medication. Two nursing staff failed to check the patients' cup and/or mouth after taking their oral medications and failed to instruct the patients to swab the testing or injection site with an alcohol swab prior to blood glucose testing or insulin injection. *This is a new critical issue.*

8.17 The narcotics logs for all three medical clinics for the month of August 2017 were reviewed. Of 186 shift changes, 172 shifts had documentation of the date and time the narcotics were inventoried by two licensed health care staff. For the 14 deficiencies, health care staff failed to note the time of the count. Although the facility scored 92.5% compliant for this question, it is a decrease from the score of 100% received in the January 2017 audit.

8.18 Six patients were interviewed by the CCHCS nurse auditor to determine if they had access to their rescue inhalers or nitroglycerine tablets while housed in the Administration Segregation Unit (ASU). Five of the six patients did not have their inhalers on their person or in their cells. *This is a new critical issue.*

Case Review Results

During the September 2017 Limited Review audit, CCHCS clinicians reviewed 84 encounters related to *Medical/Medication Management* and identified 17 deficiencies. Two deficiencies were related to provider performance and 15 were related to nursing performance. Specific physician and nurse deficiencies are documented below.

Physician

The CCHCS physician auditor reviewed 26 physician encounters related to *Medical/Medication Management* and found two deficiencies. The PCPs performed poor assessments of or failed to perform assessments on patients.

- In Case 9, the 45 year old patient presented with a complaint of five months of left sided shoulder pain. The patient was seen by the mid-level provider who appropriately consulted with supervising physician. The supervising physician recommended a Computed Tomography Angiography[4] (CT angiogram). There is no clear documentation why the CT angiogram was indicated. Concern of vascular insufficiency should have prompted the supervising physician to examine the patient.

[4] CT Angiography - A test that uses X-rays to provide detailed pictures of the heart and the blood vessels that go to the heart, lung, brain, kidneys, head, neck, legs, and arms.

- In Case 14, the 29 year old patient was sent to the emergency department on June 4, 2017, and August 31, 2017 after life threatening drug ingestion. On August 31, 2017, there is a brief observation note generated; however no follow up was scheduled to assess patient status. A follow up visit should have been scheduled after discharge from observation.

Nursing

The CCHCS nurse auditor reviewed 58 nursing encounters related to *Medical/Medication Management* and found 15 deficiencies related to the nursing performance. Deficiencies for each case are documented below:

In Cases 16, 17, 20, 22, patients were not provided their KOP medications timely. Per IMSP&P, non-urgent new medication orders received by the pharmacy on any business day must be available to the patient no later than three business days unless otherwise ordered by the PCP.

- In Case 16, on June 15, 2017, the medication Naproxen was ordered but was not received until June 24, 2017, more than three days after ordered.
- In Case 17, on June 12, 2017, a nursing note documented the nurse received a verbal order from the PCP to give the medication Ibuprofen two times a day. The medication was received late by the patient on June 16, 2017.
- In Case 20, the patient received two of his medications late. On June 11, 2017, nursing staff documented on the nursing protocol form the patient was prescribed an antifungal cream medication and the medication Ibuprofen. However the Medication Administration Records (MARs) show the cream was given late on June 21, 2017 and the patient did not receive the Ibuprofen until June 14 2017.
- In Case 22, the patient received his KOP medication late on four occasions.
    - On June 1, 2017, patient returned from the hospital and was seen by the PCP who ordered the medication Pantoprazole. The MAR shows the patient first received the medication on June 21, 2017.
    - On June 17, 2017, patient requested a refill of the Pantoprazole and also requested athlete's foot cream and dandruff shampoo. The patient did not have active orders for the cream or dandruff shampoo. Nursing staff failed to submit a refill request for the Pantoprazole and failed to refer the patient to the PCP for assessment of the need for the cream and dandruff shampoo.
    - On June 20, 2017, patient was seen for sick call complaining of diarrhea after meals and was referred to the PCP who renewed his Pantoprazole. The pharmacy records show the Pantoprazole was dispensed on June 21, 2017, however the MAR reflects the patient received the medication late on July 5, 2017.
    - The patient received a 30-day supply of Pantoprazole on July 5, 2017, and did not receive his refill until August, 18, 2017. The medication should have been received by the patient on or before August 4, 2017.

In Cases 17 and 19, patients were not referred to the PCP by nursing staff on two occasions when the patients missed three consecutive days or at least 50% of scheduled doses of NA/DOT medications

in one week. Nursing staff also failed to identify barriers when the patient failed to show for the medication.

- In Case 17, the patient missed several doses of medication in June and July 2017 and nursing staff failed to refer the patient to the PCP. On June 18, 2017, the MAR shows that the patient missed several doses of the medication Amoxicillin/Potassium Clavulanate on June 19-22, 2017. There was no documentation of the patient's refusal of the medication, identification of barriers to the patient receiving his medication, or of nursing referring the patient to the PCP for medication non-compliance. On July 20-26, 2017, the patient missed 50% of the medication Venlafaxine doses and again there was no documentation as reported above.
- In Case 19, the patient refused the medication Keppra on May 4 through May 7 and May 8 through May 14. On the week of May 8 through 14, 2017, the RN documented that she provided education and counseling regarding the patient's refusal to take the medication; however, the patient was not referred to the PCP on either week for medication non-compliance.

Nursing staff failed to have the patient sign a refusal form within a timely manner when the patient refused the Pneumovax (pneumonia) Vaccine.

- In Case 17, on May 18, 2017, the PCP ordered the Pneumovax Vaccine; however, the refusal form was not signed until July 12, 2017, nearly two months after the vaccine was ordered. The patient should have received the vaccine or signed the refusal form no later than three business days from the date of the order.

Nursing staff failed to document on the MAR that medication was given to the patient.

- In Case 17, on May 5, 2017, nursing staff documented on the nursing protocol form that the patient was given the medication Motrin; however, there was no documentation on the MAR of the patient receiving the medication.

Nursing staff failed to have the patient sign a refusal form when refusing medication.

- In Case 21, on May 29, 2017, the patient was seen due to a sick call request form complaining of pain. Nursing documented on the nursing protocol form that pain medication was offered but the patient refused. There was no refusal form signed by the patient and nursing staff failed to document the name of the medication that was offered.

Recommendations:

- Discuss expiring chronic care medications during the daily care huddle with documentation of staff assigned to follow-up on expiring medications.
- Training and performance monitoring of all nurses on direct observation therapy medication and insulin administration process.
- Provide education to patients regarding the proper procedures during blood sugar checks and insulin administration process.
- Nursing and custody collaboration during patient's intake screening upon arrival at LPCC in order to ensure patients' possession of their life-saving medications with them.

9 – OBSERVATION CELLS

The facility received an overall compliance score of 72.7% (*inadequate*) in the *Observation Cells* indicator (component) during the January 2017 audit with three critical issues identified. All sections, clinician case reviews, medical record review, and quantitative reviews, of this indicator (component) were reviewed during the Limited Review. All three critical issues from the January 2017 audit remain unresolved (Refer to Table 1.2 on page 7). Specific findings related to the provider and nurse case reviews, medical record reviews, and onsite observations are documented below.

Audit Date	NCPR Compliance Score	Provider Compliance Score	Quantitative Score
January 2017	97.2%	75.0%	45.9%
Limited Review September 2017	100%	100%	74.6%

Quantitative Review Results

During the September Limited Review, four of the six questions in this indicator (component) were reviewed. Two questions were not reviewed as there were no samples identified meeting the questions' criteria during the Limited Review. Specific deficiencies for the other questions are described below:

The PCP continued to fail to document the need for the patient's placement in the observation cell within 24 hours of placement (Question 9.2 below). This critical issue remains unresolved.

The Medical Observation Logs for June, July, and August of 2017 were reviewed to determine if nursing staff documented their daily rounds once per shift when patients were housed in the observation unit (Question 9.6 below). Nursing was required to document 164 rounds during the three month time period. However, there was appropriate documentation for only 96 rounds resulting in an *inadequate* (58.5%) compliance score. The findings are as follows:

- June 2017: There were patients in the observation cells for the whole month requiring a total of 60 rounds. There was only documentation of one shift making rounds on June 1, 5, 8, 9, 10, 12, 16, 19, 22, 25, and 26 with a total of 11 shifts missing documentation. There were no rounds on any shifts on June 4, 11, and 24 with a total of 6 shifts missing. On occasion, nursing staff recorded their rounds as 7:00 am to 7:00 pm rather than specifying the exact time such as 7:00 am to 7:15 am. The rounds documented in 12 hour shifts were not considered compliant.
- July 2017: There were no patients housed in the observation unit on July 28, therefore, a total of 60 rounds for 30 days were required. There was only documentation of one shift making rounds on July 1, 2, 4, 6, 7, 8, 10, 11, 13, 14, 15, 16, 21, 25, 26, and 27 with 16 shifts missing. There were no rounds documented on July 5, 9, 18, 24, 31, with ten shifts missing documentation. The rounds documented in 12 hour shifts were not considered compliant.
- August 2017: There were no patients housed in the observation unit on August 1-5, 19, 20, 23, and 24, therefore, a total of 44 rounds for 22 days were required. There was documentation of one shift making rounds on August 6, 9-11, 14-17, 21-22, and 25-27 with 13 shifts missing

documentation. There were no rounds documented on August 7-8, 12-13, and 30-31 with 12 shifts missing. The rounds documented in 12 hour shifts were not considered compliant.

Observation Cells (COCF Only)		**January 2017 Audit Score**	**September 2017 Limited Review Audit Score**	**Change**
9.1	Does the health care provider order patient's placement into the observation cell using the appropriate format for order entry?	100%	100%	0.0
9.2	Does the health care provider document the need for the patient's placement in the observation cell within 24 hours of placement?	0.0%	60.0%	60.0
9.3	Does the registered nurse complete and document an assessment on the day of a patient's assignment to the observation cell?	100%	80.0%	<20.0>
9.4	Does the health care provider review, modify, or renew the order for suicide precaution and/or watch at least every 24 hours?	N/A	N/A	N/A
9.5	Does the treating clinician document daily the patient's progress toward the treatment plan goals and objectives?	0.0%	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?	29.6%	58.5%	28.9
	Overall Percentage Score and Change:	**45.9%**	**74.6%**	**28.7**

Comments:

9.2 Five medical records of patients housed in an observation cell during the audit review period were reviewed. Three of the five records had documentation that the PCP documented the need for the patient's placement in the observation cell within 24 hours of placement, resulting in 60.0% compliance. *This critical issue remains unresolved and will be monitored during subsequent audits for compliance.*

9.3 Four of the five medical records of patients housed in an observation cell during the audit review period revealed the registered nurse completed and documented an assessment on the day of the patient's assignment to the observation cell. One record showed the RN documented the assessment one day late, resulting in an 80.0% compliance score which is a decrease from the 100% score received in during the January 2017 audit.

9.4 N/A There were no patients housed in an observation cell on suicide watch during the audit review period, therefore this question was not evaluated during the Limited Review.

9.5 N/A There were no patients housed in an observation cell on suicide watch during the audit review period, therefore this question was not evaluated during the Limited Review. *This critical issue remains unresolved and will be monitored during subsequent audits for compliance.*

9.6 The facility received a 58.5% compliance score for the Medical Observation Logs reviewed during the audit review period. Specific deficiencies are noted above. *This critical issue remains unresolved and will be monitored during subsequent audits for compliance.*

Case Review Results

During the current Limited Review, CCHCS clinicians reviewed 31 encounters related to treatment provided to patients housed in observation cells. The facility received a proficient (100%) score for both physician and nursing case reviews for this indicator (component).

Recommendations:

- Staff training on the proper use of and documentation in the Medical Observation Unit log book.

10 - SPECIALTY SERVICES

Quantitative Review Results

The facility received an overall quality indicator score of 94.4% (*proficient*) in *Specialty Services* during the January 2017 audit with the identification of one critical issue. This critical issue was the only item that required evaluation for this indicator (component) during the Limited Review and remains deficient.

Specialty Services		**January 2017 Audit Score**	**September 2017 Limited Review Audit Score**	**Change**
10.3	Upon the patient's return from the specialty services appointment, did the RN notify the PCP of any immediate medication or follow-up requirements provided by the specialty consultant?	53.3%	50.0%	<3.3>

Comments:

10.3 The CCHCS nurse auditor reviewed four medical records of patients who returned from a specialty services appointment during the audit review period. Two records had documentation of the RN notifying the PCP of any immediate medication or of follow-up requirements provided by the specialty consultant and two failed to have documentation. *This critical issue remains unresolved and will be monitored during subsequent audits for compliance.*

11 - PREVENTIVE SERVICES

During the January 2017 audit, LPCC received an overall indicator (component) score of 80.0% (*adequate*) for the *Preventative Services* indicator (component). The facility was found deficient in offering colorectal cancer screening to the patient population 50-75 years of age. This critical issue was not evaluated during the Limited Review as the review for this question is only completed annually to avoid duplicate selection from the sample pool. The critical issue is considered unresolved and will be monitored during subsequent audits to determine compliance.

12 - EMERGENCY MEDICAL RESPONSE/DRILLS and EQUIPMENT

During the January 2017 audit, the facility received an overall quality indicator (component) compliance score of 96.4% (*proficient)* in Emergency *Medical Response/Drills and Equipment* with one critical issue identified. During the Limited Review, the facility received a 99.6% compliance score for the critical issue question. Therefore this critical issue is resolved.

	Emergency Medical Response/Drills & Equipment	**January 2017 Audit Score**	**September 2017 Limited Review Audit Score**	**Change**
12.9	*Emergency Medical Equipment:* Was the facility's Medical Emergency Crash Cart secured with a seal? (COCF Only)	78.3%	99.6%	21.3

Comments:

12.9 The facility received a compliance score of 99.6% during the Limited Review which is a significant improvement from the 78.3% compliance score received during the January 2017 audit. *This critical issue has been resolved by the facility.*

13 - CLINICAL ENVIRONMENT

Quantitative Review Results

LPCC received an overall compliance score of 98.2% (*proficient*) for *Clinical Environment* Quality during the January 2017 audit, with identification of one critical issue which was found resolved during the Limited Review. LPCC provided documentation showing consistent completion of environmental cleaning of common clinic areas with high foot traffic at least once a day in all medical clinics, thereby resolving this critical issue.

	Clinical Environment	**January 2017 Audit Score**	**September 2017 Limited Review Audit Score**	**Change**
13.8	Is environmental cleaning of common clinic areas with high foot traffic completed at least once a day?	75.0%	100%	25.0

Comments:

None

CRITICAL ISSUE REVIEW

The health care audit conducted in January 2017, resulted in the identification of 27 quantitative and two qualitative critical issues. During the current Limited Review, auditors found 18 of the 29 items resolved, with the eight not resolved within acceptable standards. There were no samples identified during the Limited Review for three critical issues and they will be reviewed during the next audit to monitor compliance. Below is a discussion of each critical issue.

Critical Issue	Status	Comment
Question 1.1 – *THE MEDICATION NURSE AND MEDICAL RECORDS CLERK DO NOT KNOW HOW TO ACCESS ALL THE HEALTH CARE POLICIES AND PROCEDURES.*	**Resolved**	This critical issue was identified during the January 2017 audit. Two of the five staff (60.0%) interviewed were unable to explain the process to access the facility's health care policies and procedures. During the current Limited Review, all five staff (100%) interviewed were able to demonstrate access the facility's health care policies and procedures. ***This critical issue has been resolved by the facility.***
Question 1.2 - *THE FACILITY'S LOCAL OPERATING PROCEDURS/POLICIES ARE NOT ALL IN COMPLIANCE WITH THE INMATE MEDICAL SERVICES POLICIES AND PROCEDURES.*	**Unresolved**	This critical issue was identified during the January 2017 audit. During the January 2017 audit, eight of 14 (57.1%) of the facility's 14 health care policies reviewed were found non-compliant with IMSP&P. During the September Limited Review audit, two out of 13 health care policies and procedures reviewed were non-compliant. The Chronic Care Policy is no longer reviewed as it was removed from the IMSP&P in March 2017. ***This critical issue has been resolved by the facility.***
Question 1.4 – *THE PATIENT ORIENTATION HANDBOOK DOES NOT DESCRIBE THE SICK CALL OR HEALTH CARE GRIEVANCE PROCESS IN DETAIL.*	**Resolved**	This critical issue was identified during the January 2017 audit. The sick call process noted in the patient handbook was not compliant with IMSP&P. During the September Limited Review the handbook was found to have been revised in August 2017 and was updated to be compliant with IMSP&P. ***This critical issue has been resolved by the facility.***
Question 1.7 – *THE FACILITY DOES NOT PROVIDE PATIENTS WITH THEIR REQUESTED COPIES OF MEDICAL RECORDS WITHIN 15 BUSINESS DAYS.*	**Resolved**	This critical issue was identified during the January 2017 audit when eight out of 20 (60.0%) patient requests for copies of their medicals records were completed within the required time frame. During the Limited Review, 18 out of 20 (90.0%) of the requests reviewed were completed within the required time frame. ***This critical issue has been resolved by the facility.***
Question 2.2 – *THE FACILITY'S QUALITY MANAGEMENT COMMITTEE REVIEW PROCESS DOES NOT DOCUMENT A CORRECTIVE ACTION PLAN FOR IDENTIFIED OPPORTUNITES FOR IMPROVEMENT.*	**Resolved**	This critical issue was identified during the January 2017 audit. During the January 2017 audit, the facility received a compliance score of 33.3%. During the September 2017 Limited Review, the facility received a 100% compliance score. ***This critical issue has been resolved by the facility.***

Question 2.5 – *THE FACILITY DOES NOT ACCURATELY DOCUMENT ALL DATES ON THE SICK CALL MONITORING LOG.*	**Unresolved**	This critical issue was first identified during the June 2015 audit. During the January 2017 audit, the facility received a 46.3% compliance score and received a 78.9% compliance score during the September Limited Review audit. ***This critical issue is unresolved and will be monitored during subsequent audits for compliance.***
Question 2.6 – *THE FACILITY DOES NOT ACCURATELY DOCUMENT ALL THE DATES ON THE SPECIALTY SERVICES MONITORING LOG.*	**Resolved**	This has been an outstanding critical issue since the June 2015 audit. During the January 2017 audit, the facility received a 72.5% compliance score and received a 97.0% compliance score during the September Limited Review audit. ***This critical issue has been resolved by the facility.***
Question 2.7 – *THE FACILITY DOES NOT ACCURATELY DOCUMENT ALL THE DATES ON THE HOSPITAL STAY/EMERGENCY DEPARTMENT MONITORING LOG.*	**Resolved**	This has been an outstanding critical issue since the June 2015 audit. During the January 2017 audit, the facility received a 73.0% compliance score and received a 96.4% compliance score during the September Limited Review audit. ***This critical issue has been resolved by the facility.***
Question 2.8 - *THE FACILITY DOES NOT ACCURATELY DOCUMENT ALL THE DATES ON THE CHRONIC CARE MONITORING LOG.*	**Resolved**	This has been an outstanding critical issue since the June 2015 audit. During the January 2017 audit, the facility received a 78.3% compliance score and received a 95.0% compliance score during the September Limited Review audit. ***This critical issue has been resolved by the facility.***
Question 2.9 – *THE FACILITY DOES NOT ACCURATELY DOCUMENT ALL THE DATES ON THE INTIAL INTAKE SCREENING MONITORING LOG.*	**Resolved**	This has been an outstanding critical issue since the June 2015 audit. During the January 2017 audit, the facility received a 71.7% compliance score and received a 100% compliance score during the September Limited Review audit. ***This critical issue has been resolved by the facility.***
Question 2.10 – *THE FACILITY DOES NOT MAKE THE CDCR FORM 602 HC, PATIENT INMATE HEALTH CARE APPEALS ACCESSIBLE TO THE PATIENT POPULATION.*	**Resolved**	This critical issue was identified during the January 2017 audit. During the January 2017 audit, not all housing units had the CDCR Form 602 HC readily available to the patient population resulting in three out of 27 (11.1%) housing units being compliant. During the September 2017 Limited Review, all housing units (100%) had a supply of the newly revised CDCR 602 HC (Rev. 6/17) forms readily available to the patient population. ***This critical issue has been resolved by the facility.***
Question 2.13 – *THE FIRST LEVEL HEALTH CARE GRIEVANCES/APPEALS ARE NOT BEING PROCESSED WITHIN THE SPECIFIED TIME FRAMES.*	**Unresolved**	Processing for first level health care grievances has been deficient since February 2016. During the January 2017 audit, only 87 out of 121 (72.4%) grievances reviewed were processed within the required time frame. During the September 2017 Limited Review, 36 of the 61 (59.0%) grievances reviewed were processed within the required timeframe. ***This critical issue is unresolved and will be monitored during subsequent audits for compliance.***

Question 3.5 – *THE FACILITY DOES NOT HAVE THE REQUIRED HEALTH CARE STAFF COMPLEMENT.*	**Unresolved**	This critical issues was identified during the February 2016 audit. During the January 2017 audit, the facility was found to not have the full complement of PCPs, RNs, licensed practical nurses (LPN), and medical record clerks (MRC). During the September 2017 Limited Review audit, the facility still had LPN, RN and MRC vacancies. ***This critical issue is unresolved and will be monitored during subsequent audits for compliance.***
Question 3.6 – *THE FACILITY DOES NOT COMPLETE THE PCP PEER REVIEWS ON TIME.*	**Resolved**	This critical issue was identified during the January 2017 audit. During the Limited Review, all PCPs had received their peer reviews within the required time frame. ***This critical issue has been resolved by the facility.***
Question 4.8 – *THE FACILITY HEALTH CARE STAFF DOES NOT CONSISTENTLY CONDUCT DAILY CARE TEAM HUDDLES.*	**Unresolved**	This critical issue was identified during the January 2017 audit. During the January 2017 audit, the daily care team huddle documentation submitted by two of the three medical compounds was found to be missing substantial information. During the September 2017 Limited Review audit, the documentation submitted by two of the three medical compounds were again lacking substantial information. ***This critical issue is unresolved and will be monitored during subsequent audits for compliance.***
Question 4.10 – *THE FACILITY DOES NOT MAKE THE CDCR FORM 7362, HEALTH CARE SERVICES REQUEST, OR SIMILAR FORM ACCESSIBLE TO THE PATIENT POPULATION.*	**Resolved**	This critical issue was identified during the January 2017 audit. During the January 2017 audit, not all housing units had *Health Care Services Request* (sick call) forms readily available to the patient population resulting in three out of 27 (11.1%) housing units compliant. During the September 2017 Limited Review, all housing units (100%) had a supply of sick call request forms readily available to the patient population. ***This critical issue has been resolved by the facility.***
Question 5.4 – *THE FACILITY DOES NOT CONSISTENTLY PROVIDE PATIENTS WITH WRITTEN NOTIFICATION OF THEIR DIAGNOSTIC TEST RESULTS WITHIN TWO BUSINESS DAYS OF RECEIPT OF RESULTS.*	**Resolved**	This has been an outstanding critical issue since the June 2015 audit. During the January 2017 the facility received a score of 55.6% for this question. During the September Limited Review audit, nine out of 11 records (81.8%) reviewed showed the patients received notification timely. ***This critical issue has been resolved by the facility.***
Question 8.1 – *CHRONIC CARE MEDICATIONS ARE NOT CONSISTENTLY RECEIVED BY THE PATIENT WITHIN THE REQUIRED TIME FRAME.*	**Unresolved**	This has been an outstanding critical issue since the June 2015 audit. During the January 2017 audit, 11 out of 24 records (45.8%) reviewed showed patients received their chronic care medications within the required time frame. During the September Limited Review audit, one out of 16 records (6.3%) reviewed showed the patient received his medication timely. ***This critical issue is unresolved and will be monitored during subsequent audits for compliance.***

Question 8.3 – *THE NURSING STAFF DO NOT CONSISTENTLY REFER THE PATIENTS TO THE PROVIDER WHEN THEY DO NOT SHOW OR REFUSE THE NURSE ADMINISTERED/DIRECT OBSERVATION THERAPY MEDICATIONS FOR THREE CONSECUTIVE DAYS OR 50 PERCENT OR MORE DOSES IN A WEEK.*	**Unresolved**	This has been an outstanding critical issue since the June 2015 audit. During the January 2017 audit, two records reviewed showed the patients missed doses of their NA/DOT medications requiring referral to the provider, however, neither patient was referred. During the September Limited Review audit, there were no patients identified who met the criteria for this question, therefore compliance could not be evaluated. ***This critical issue remains unresolved and will be monitored during subsequent audits for compliance.***
Question 8.13 – *THE FACILITY'S NURSING STAFF ARE NOT ALL KNOWLEDGEABLE ON THE PROCESS OF DOCUMENTING MEDICATION ERRORS.*	**Resolved**	This critical issue was identified during the January 2017 audit. None of the six (0.0%) nursing staff interviewed were knowledgeable on the process of documenting medication errors. During the September Limited Review audit, all six (100%) nursing staff interviewed were knowledgeable on documenting medication errors. ***This critical issue has been resolved by the facility.***
Question 9.2 – THE FACILITY PROVIDERS ARE NOT DOCUMENTING THE NEED FOR THE PATIENT'S PLACEMENT IN THE OBSERVATION CELL WITHIN 24 HOURS OF PLACEMENT.	**Unresolved**	This critical issue was identified during the January 2017 audit. During the January 2017 audit, one patient met the criteria for placement in an observation cell. The facility provider failed to document the need for placement in the observation cell within 24 hours of placement resulting in 0.0% compliance. During the September Limited Review audit, five records of patients placed in an observation cell were reviewed. The provider documented the need for placement in the observation cell within 24 hours of placement for three of the five (60.0%) patients. ***This critical issue is unresolved and will be monitored during subsequent audits for compliance.***
Question 9.5 – *THE TREATING CLINICIAN DOES NOT DOCUMENT DAILY THE PATIENT'S PROGRESS TOWARD THE TREATMENT PLAN GOALS AND OBJECTIVES FOR PATIENTS HOUSED IN OBSERVATION CELL FOR SUICIDE PRECAUTION AND/OR WATCH.*	**Unresolved**	This critical issue was identified during the January 2017 audit. During the January 2017 audit, one patient met the criteria for placement in an observation cell on suicide watch. The facility provider failed to document the patient's progress toward the treatment plan goals and objectives daily resulting in 0.0% compliance. During the September Limited Review audit, there were no patients identified who were placed in an observation cell on suicide watch, therefore this question could not be evaluated during the Limited Review. ***This critical issue remains unresolved and will be monitored during subsequent audits for compliance.***

Question 9.6 – *THE NURSING STAFF IS NOT DOCUMENTING THEIR DAILY ROUNDS ONCE PER WATCH IN THE UNIT LOG BOOK WHEN A PATIENT IS HOUSED IN THE OBSERVATION UNIT.*	**Unresolved**	This critical issue was identified during the January 2017 audit. During the January 2017 audit, it was identified that LPCC did not utilize a log book for nursing staff to document daily rounds once per watch in the Observation Unit. Out of 54 shifts reviewed, 16 rounds (29.6%) were documented. During the September Limited Review audit, 96 out of 164 (58.5%) shifts reviewed, showed nursing staff documented the time the daily round was completed on their watch. ***This critical issue remains unresolved and will be monitored during subsequent audits for compliance.***
Question 10.3 – *THE REGISTERED NURSE DOES NOT CONSISTENTLY NOTIFY THE PROVIDER OF ANY IMMEDIATE ORDERS OR FOLLOW-UP INSTRUCTIONS PROVIDED BY THE SPECIALTY CARE CONSULTANT APPOINTMENT.*	**Unresolved**	This has been an outstanding critical issue since the June 2015 audit. During the January 2017 audit, eight out of 15 (53.3%) records reviewed were compliant with this question. During the September 2017 Limited Review audit, there were four records which met the criteria for this question. Two of the four records (50.0%) showed nursing staff failed to notify the provider of any immediate orders or follow-up instructions provided by the specialty care consultant after a specialty appointment. ***This critical issue is unresolved and will be monitored during subsequent audits for compliance.***
Question 11.3 – *THE FACILITY DOES NOT CONSISTENTLY OFFER COLORECTAL CANCER SCREENING TO THE PATIENT POPULATION 50-75 YEARS OF AGE.*	**Unresolved**	This critical issue was identified during the January 2017 audit. During the January 2017 audit, six out of 15 (40.0%) records reviewed showed LPCC was compliant with offering colorectal cancer screening as required. This question is reviewed annually and was not reviewed during the current September 2017 Limited Review**. Therefore, this *critical issue remains unresolved and will be monitored during subsequent audits for compliance.***
Question 12.9 – *THE FACILITY DOES NOT USE A SINGULAR SEAL ON EACH CRASH CART.*	**Resolved**	This critical issue was identified during the January 2017 audit. During the January 2017 audit, the facility received a compliance score of 78.3% for this question. During the September 2017 Limited Review audit, the facility received a compliance score of 99.6%. ***This critical issue has been resolved by the facility.***

Question 13.8 – *COMPOUND 2 MEDICAL CLINIC DID NOT HAVE DOCUMENTATION THAT SHOWED ENVIRONMENTAL CLEANING WAS CONDUCTED.*	**Resolved**	This critical issue was identified during the January 2017 audit. During the January 2017 audit, one of the three compounds did not have documentation showing environmental cleaning was conducted daily. Therefore, only 66 of the 88 days (75.0%) reviewed for all three compounds had documentation of daily environmental cleaning. During the September Limited Review audit, the facility was 100% compliant with environmental cleaning in all three compounds. ***This critical issue has been resolved by the facility.***
Qualitative Critical Issue #1 – *CUSTODY STAFF ARE NOT CONSISTENTLY PICKING UP PATIENTS' MEDICAL DUCATS AND DISTRIBUTING TO THE PATIENTS.*	**Resolved**	This critical issue was identified during the January 2017 audit. During the January 2017 audit, it was identified that custody staff did not consistently pick up patients' medical ducats and distribute them to the patients. During the September 2017 Limited Review, LPCC's HSA provided documentation of custody staff distributing the medical ducats and requiring the patient to sign he received the ducat. ***This critical issue has been resolved by the facility.***
Qualitative Critical Issue #2 – *CUSTODY STAFF ARE DENYING PATIENT ACCESS TO MEDICAL CARE BY MAKING MEDICAL JUDGEMENTS ON PATIENTS' MEDICAL NECESSITY.*	**Resolved**	This critical issue was identified during the January 2017 audit. During the January 2017 audit, custody staff was placing patients' sick call requests into their desk drawers until the end of their shift and then would place them into the facility mail. During the September 2017 Limited Review, custody staff in the housing units were asked the process for patient's to request medical attention. Custody staff reported the patient would complete a sick call request form and place it directly into the locked sick call box in the housing unit. ***This critical issue has been resolved by the facility.***

NEW CRITICAL ISSUES

New Critical Issues Identified – La Palma Correctional Center	
Question 8.5	The facility failed to administer anti-TB medications to patients as prescribed.
Question 8.7	PCP staff failed to document that the patient was provided education on newly prescribed medication(s).
Question 8.8	The facility health care staff failed to administer the initial dose of newly prescribed medication to the patient as ordered by the provider.
Question 8.11	The nursing staff failed to directly observe the patient taking NA/DOT medication.
Question 8.18	The facility failed to ensure patients housed in the administrative segregation unit who are prescribed short acting beta agonist inhalers or nitroglycerin tablets have them on their person (in their cells).
Qualitative Issue #1	Health care appeals were received and screened by non-health care staff.

CONCLUSION

During the September 2017 onsite Limited Review audit, the CCHCS auditors met with the facility's Inmate Advisory Committee (IAC) to discuss issues related to health care. Committee members raised concerns of mold in the showers of their housing units. The IAC members felt the chemicals used to clean the showers were not adequate to combat the mold. After the meeting, the CCHCS HSP I auditor inspected the shower area in the Zuni Bravo housing unit. The CCHCS auditor observed a large amount of what appeared to be mold on the shower walls. The CCHCS auditors discussed the issue with facility management who reported the porters who clean the showers have access to the appropriate chemicals to clean the shower areas. The CCHCS HPS I requested the showers be cleaned and upon re-inspection the following day, the shower was found to have been cleaned with no mold visible. The facility management reported that they will ensure shower porters in each housing unit are given the correct chemicals and adequate time to perform cleaning of the showers.

During the current Limited Review audit, the five quality indicators (components) which failed to receive a passing overall scores during the January 2017 audit, received passing scores above the 80% compliance threshold. LPCC resolved 18 of the 29 critical issues from the January 2017 audit. Of the eight critical issues remaining unresolved, two have been outstanding since the June 2015 audit, two from the February 2016 audit, and four from the January 2017 audit. There were no samples identified during the Limited Review for three critical issues and they will be reviewed during the next audit to evaluate compliance. There were also six new critical issues identified during the September 2017 Limited Review.

While the *Medical/Medication Management* indicator (component) received a passing overall score of 80.7% (*adequate),* during the Limited Review, numerous deficiencies related to medication administration continues to impact patient care. This indicator (component) is critical to the provision of adequate health care. LPCC has failed to resolve the critical issue related to patients not receiving their chronic care

medications timely since the June 2015 audit. In addition, five new critical issues were identified during the September 2017 Limited Review, which include the facility's failure to administer newly prescribed, critical medications, and NA/DOT medications as ordered. These deficiencies indicate the facility is not being diligent in providing adequate health care services in regards to medication management. The facility is admonished to immediately work to resolve all critical issues, paying particular attention to the one related to patients receiving their chronic care medication which has been deficient for over two years.

The *Observation Cell* indicator (component) received an overall rating of *proficient* (91.6%). However, the facility continues to struggle with the requirement of PCP staff to document the need for patients' placement in the observation cell within 24 hours of placement and nursing staff's failure to appropriately document their nursing rounds in the medical observation log book on each shift.

The facility's policies and LOPs are required to be updated to reflect changes in the IMSP&P. Eleven of the 13 LOPs reviewed were found to be compliant. One LOP was scored N/A as it is no longer found in the IMSP&P. The LOPs that were out of compliance have impacted the outcome of this audit. This is problematic since the health care staff cannot meet the expected health care delivery standards without adequate knowledge and training of these LOPs. As suggested in the January 2017 audit report, it is recommended that CoreCivic's executive management work diligently to bring the two remaining LOPs into compliance with IMSP&P and provide ongoing training on the LOPs to health care staff.

While the CCHCS auditors found that the overall delivery of health care at LPCC to be adequate, continued training of health care staff is needed. It is imperative that executive and health care management work together to provide training to health care staff to ensure LPCC is providing an adequate level of health care to California patients. As stated above, training should include LOPs, medication administration especially to include appropriate/timely medication administration, required documentation of daily care huddles, and use and documentation of the Medical Observation Unit log book. In addition, continued training for nursing staff on nursing requirements upon a patient's return from an offsite specialty clinic is also recommended.

The deficiencies mentioned in this report are easily correctable and are within the management's scope of control to ensure compliance. If these critical issues are left unaddressed, they may create barriers preventing the patients from receiving an adequate level of health care.

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

Private Prison Compliance and Monitoring Unit
Matrix of Facility's Dispute of Quantitative Findings

La Palma Correctional Center (LPCC) Health Care Compliance and Monitoring Audit
Onsite Audit: September 25-29, 2017
Audit Review Period: May - Aug. 2017

Q#	Critical Issue	Compliance Score	LPCC's Rebuttal Response	Supporting Documentation Attached?	Answers Changed as Result of Comment?	CCHCS's Final Disposition/Comment
1.2	The facility's local operating procedures/policies are not all in compliance with the Inmate Medical Services Policies and Procedures. ***This is an unresolved critical issue from the January 2017 audit.***	76.9%	(1) Daily Huddles - Information regarding daily huddles was included in CoreCivic Policy 13-80, "Sick Call" on page 1. (2) Patient's Transfer Envelope - CoreCivic policy 13-86, "Transfer and Community Release", addresses all of the items required for the transport packet as required by IMSP&P. Refer to pages 2, 4 and 5 of the policy. (3) Annual Training for Health Care Staff - CoreCivic Policy 13-56, "Credentialing, Privileging, Licensure and Continuing Education", addresses the annual training requirement on page 17 as does CoreCivic Policy 4-1, Learning and Development (page 9).	Yes	(1) No change in decision. (2) No change in decision (3) Changed to compliant	(1) The facility merely defined "Daily Care Huddle" but did not explain the required elements of daily care huddle, which include but not limited to the following: mandatory time for holding it, members of the daily care huddle, issues to discuss, and the required documentation. The required documentation includes action taken, follow-up or recommendations for issues identified. (Ref: IMSP&P Vol 4, Chapt 1.2 *Care Teams and Patient Panels Procedure*). ***This policy remains non-compliant.*** (2) Patient's Transfer Envelope: The submitted supporting documentation only highlighted the elements of the Transfer Summary. The Transfer Summary is just one of the required documents to be placed in the White Transfer Envelope. Other documents include the MAR, medication reconciliation form, active doctor's order, Disability Placement Program Verification form, Comprehensive Accomodation Chrono form, transfer checklist, etc. (IMSP&P Vol 4, Chapter 3.2, *Health Care Transfer Procedure*). ***This policy remains non-compliant.*** (3) The CoreCivic Policy 13-56, Credentialing, Privileging, Licensure and Continuing Education does address the annual training requirements as the facility stated. ***This policy is considered compliant*** .