CORRECTIONAL MEDICAL AUTHORITY

PHYSICAL & MENTAL HEALTH SURVEY

of

Blackwater River Correctional Facility

In

Milton, Florida

on

June 14-16, 2016

CMA Staff Members
Kathy McLaughlin, BS
Monica Dodrill, RN
Jane Holmes-Cain, LCSW

Clinical Surveyors
Hantz Hercule, MD
John Bailey, DO
Tim Garvey, DMD
Marcellus Taylor, PhD
Julie Holt, ARNP
Deanna Epley, ARNP
Sue Sims, RN
Patricia Meeker, RN
Russell Irish, RN
Jennifer Barr, LCSW
Dynitia Brimm, LCSW

Distributed on July 6, 2016

CAP Due Date August 5, 2016

DEMOGRAPHICS

The institution provided the following information in the Pre-survey Questionnaire.

INSTITUTIONAL INFORMATION			
Population	**Type**	**Custody Level**	**Medical Level**
1993	**Male**	**Close**	**3**

Institutional Potential/Actual Workload

Main Unit Capacity	**2000**	**Current Main Unit Census**	**1993**
Satellite Unit(s) Capacity	**N/A**	**Current Satellite(s) Census**	**N/A**
Total Capacity	**2000**		**1993**

Inmates Assigned to Medical/Mental Health Grades

Medical Grade	***1***	***2***	***3***	***4***	***5***	***Impaired***
	1053	**905**	**58**	**N/A**	**N/A**	**34**
Mental Health Grade (S-Grade)	***Mental Health Outpatient***			***MH Inpatient***		
	1	***2***	***3***	***4***	***5***	***Impaired***
	1584	**95**	**337**	**N/A**	**N/A**	**N/A**

Inmates Assigned to Special Housing Status

Confinement/ Close Management	***DC***	***AC***	***PM***	***CM3***	***CM2***	***CM1***
	45	**31**	**0**	**0**	**0**	**0**

DEMOGRAPHICS

Medical Staffing: Main Unit

	Number of Positions	Number of Vacancies
Physician	1	0
Clinical Associate	1	1
RN	10	4
LPN	11	1
CMT-C	0	0
Dentist	1	0
Dental Assistant	1	0
Dental Hygienists	1	0

Mental Health Staffing: Main Unit

	Number of Positions	Number of Vacancies
Psychiatrist	0.5	0
Psychiatrist ARNP/PA	0	0
Psychological Services Director	1	0
Mental Health Professional	3	1
Human Services Counselor	0	0
Mental Health RN	1	1
Mental Health LPN	0	0

OVERVIEW

Blackwater River Correctional Facility (BRCF) houses male inmates of minimum and medium custody levels. The facility grades are medical (M) grades 1, 2, and 3, and psychology (S) grades 1, 2, and 3. BRCF consists of a Main Unit.

The overall scope of services provided at BRCF include comprehensive medical, dental, mental health, and pharmaceutical services. Specific services include: health education, preventive care, chronic illness clinics, emergency care, infirmary services, and outpatient mental health care.

The Correctional Medical Authority (CMA) conducted a thorough review of the medical, mental health, and dental systems at BRCF on June 14-16, 2016. Record reviews evaluating the provision and documentation of care were also conducted. Additionally, a review of administrative processes and a tour of the physical plant were conducted.

Based on the number and clinical significance of the findings, as well as the lack of systems in place to ensure appropriate care is provided, the CMA has serious concerns regarding the provision of care at this institution. It is the expectation of the CMA that these findings will be the focus of the mental/physical health providers and that corrective action monitoring will lead to immediate improvement of health care services. Depending on the results of corrective actions produced in response to this report, the CMA may re-survey BRCF in the coming fiscal year.

Exit Conference and Final Report

The survey team conducted an exit conference via telephone with institutional personnel to discuss preliminary survey results. The findings and final conclusions presented in this report are a result of further analysis of the information collected during the survey. The suggested corrective actions included in this report should not be construed as the only action required to demonstrate correction, but should be viewed as a guide for developing a corrective action plan. Where recommended corrective actions suggest in-service training, a copy of the curriculum and attendance roster should be included in the corrective action plan files. Additionally, evidence of appropriate biweekly monitoring should be included in the files for each finding. Unless otherwise specified, this monitoring should be conducted by an institutional clinician/peer and documented by a biweekly compilation of the following:

1) The inmate names and DC numbers corresponding to the charts (medical records) reviewed;
2) The criteria/finding being reviewed;
3) An indication of whether the criteria/finding was met for each chart reviewed;
4) The percentage of charts reviewed each month complying with the criteria;
5) Back-up documentation consisting of copies of the relevant sections reviewed from the sampled charts.

PHYSICAL HEALTH FINDINGS

Blackwater River Correctional Facility (BRCF) provides inpatient and outpatient physical health services. The following are the medical grades used by the Department to classify inmate physical health needs at BRCF:

- M1 - Inmate requires routine care (periodic screening, sick call, emergency care).
- M2 - Inmate is being followed in a chronic illness clinic (CIC) but is stable and does not require CIC care more often than six months.
- M3 - Inmate is being followed in a CIC every three months.

CLINICAL RECORDS REVIEW

CHRONIC ILLNESS RECORD REVIEW

There were findings requiring corrective action in eight of the chronic illness clinics and in the general chronic illness clinic review; the items to be addressed are indicated in the tables below.

EPISODIC CARE REVIEW

There were no findings requiring corrective action in the review of sick call. There were findings requiring corrective action in the review of emergency care and infirmary services; the items to be addressed are indicated in the tables below.

OTHER MEDICAL RECORD REVIEW

There were no findings requiring corrective action in the review of intra-system transfers. There were findings requiring corrective action in the review of consultations, medication administration, periodic screenings, and inmate requests; the items to be addressed are indicated in the tables below.

DENTAL REVIEW

There were no findings requiring corrective action in the review of dental systems or dental care.

ADMINISTRATIVE PROCESSES REVIEW

There were no findings requiring corrective action in the review of pharmacy services or the pill line. There were findings requiring corrective action in the review of infection control; the item to be addressed is indicated in the table below.

INSTITUTIONAL TOUR

There were findings as a result of the institutional tour; the items to be addressed are indicated in the table below.

Chronic Illness Clinic Record Review	
Finding(s)	**Suggested Corrective Action(s)**
A comprehensive review of 15 records revealed the following deficiencies: **PH-1: In 12 of 14 applicable records, the baseline information was incomplete or missing (see discussion).** **PH-2: In 9 of 14 applicable records, patient education was incomplete or missing (see discussion).** **PH-3: In 1 of 1 applicable record, an inmate was not seen during the appropriate timeframe (see discussion).**	Provide in-service training to staff regarding the issue(s) identified in the Finding(s) column. Create a monitoring tool and conduct biweekly monitoring of no less than ten records of those enrolled in a chronic illness clinic to evaluate the effectiveness of corrections. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Discussion PH-1: *Health Services Bulletin (HSB) 15.03.05 states that the initial clinic visit shall include baseline data documented on the appropriate DC4-770 series. The DC4-770 series includes the "Clinic Flow Sheet(s)" and the "Baseline History and Procedures". The initial visit often takes place at the reception centers or when a new case develops at the institutional level. If the baseline data is not available at the initial visit, it should be documented when it becomes available. In all twelve records, the baseline history and procedures portion was missing.*

Discussion PH-2: *Per form instructions, education is to be documented on the DC4-770 by entering the corresponding number of relevant education provided as: 1. Disease process, 2. Risk reductions, 3. Smoking Cessation (if applicable), 4. Medication(s), 5. Treatment Compliance. In all deficient records, no numbers were recorded.*

Discussion PH-3: *The inmate was diagnosed with ulcerative colitis as a result of a colonoscopy on 4/25/16. Progress notes indicated that he should be enrolled and seen in clinic in two weeks for follow-up. There was no record that the inmate had a clinic visit as of the date of the survey.*

Cardiovascular Clinic Record Review	
Finding(s)	**Suggested Corrective Action(s)**
PH-4: In 2 of 10 applicable records (15 reviewed), there was no evidence of a referral to a specialist when indicated (see discussion).	Provide in-service training to staff regarding the issue(s) identified in the Finding(s) column. Create a monitoring tool and conduct biweekly monitoring of no less than ten records of those enrolled in the cardiovascular clinic to evaluate the effectiveness of corrections. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Discussion PH-4: *In one record, an inmate with coronary artery disease and a stent had not seen a cardiologist in several years. In the other record, the inmate had not had an eye examination. Per Health Services Bulletin (HSB) 15.03.05 Appendix #4, inmates in the cardiovascular clinic are to receive fundoscopic examinations.*

Endocrine Clinic Record Review	
Finding(s)	**Suggested Corrective Action(s)**
A comprehensive review of 18 records revealed the following deficiencies: **PH-5: In 3 of 9 applicable records, there was no evidence of an annual fundoscopic examination.** **PH-6: In 1 of 5 applicable records, there was no evidence that an inmate with HgbA1c over 8.0 was seen at least every three months.** **PH-7: In 2 of 10 applicable records, aspirin therapy was not initiated for inmates with vascular disease or risk factors for vascular disease.**	Provide in-service training to staff regarding the issue(s) identified in the Finding(s) column. Create a monitoring tool and conduct biweekly monitoring of no less than ten records of those enrolled in the endocrine clinic to evaluate the effectiveness of corrections. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Gastrointestinal Clinic Record Review	
Finding(s)	**Suggested Corrective Action(s)**
A comprehensive review of 16 records revealed the following deficiencies: **PH-8: In 8 of 14 applicable records, there was no evidence of hepatitis A & B vaccination or refusal.** **PH-9: In 3 of 15 applicable records, there was no evidence of pneumococcal vaccination or refusal.**	Provide in-service training to staff regarding the issue(s) identified in the Finding(s) column. Create a monitoring tool and conduct biweekly monitoring of no less than ten records of those enrolled in the gastrointestinal clinic to evaluate the effectiveness of corrections. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Miscellaneous Clinic Record Review	
Finding(s)	**Suggested Corrective Action(s)**
A comprehensive review of 12 records revealed the following deficiencies: **PH-10: In 2 of 10 applicable records, there was no evidence that prescribed medication was received (see discussion).** **PH-11: In 2 of 7 applicable records, there was no evidence of pneumococcal vaccination or refusal.** **PH-12: In 2 of 10 applicable records, there was no evidence of influenza vaccination or refusal.**	Provide in-service training to staff regarding the issue(s) identified in the Finding(s) column. Create a monitoring tool and conduct biweekly monitoring of no less than ten records of those enrolled in the miscellaneous clinic to evaluate the effectiveness of corrections. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Discussion PH-10: *In both records, surveyors were unable to determine if prescribed medication was received. There was no record in the keep-on-person (KOP) medications files and there was not a medication administration record (MAR) to indicate distribution. One inmate was prescribed Lasix for hypertension and the other was prescribed Xalatan for glaucoma.*

Neurology Clinic Record Review	
Finding(s)	**Suggested Corrective Action(s)**
PH-13: In 7 of 14 records reviewed, seizures were not classified as primary generalized (tonic-clonic, grand mal), primary or simple absence (petit mal), simple partial, or complex partial seizures.	Provide in-service training to staff regarding the issue(s) identified in the Finding(s) column. Create a monitoring tool and conduct biweekly monitoring of no less than ten records of those enrolled in the neurology clinic to evaluate the effectiveness of corrections. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Oncology Clinic Record Review	
Finding(s)	**Suggested Corrective Action(s)**
A comprehensive review of 7 records revealed the following deficiencies: **PH-14: In 3 records, there was no evidence of a proper diagnosis for the clinic (see discussion).** **PH-15: In 2 of 4 applicable records, there was no evidence of a referral to a specialist when indicated (see discussion).**	Provide in-service training to staff regarding the issue(s) identified in the Finding(s) column. Create a monitoring tool and conduct biweekly monitoring of no less than ten records of those enrolled in the oncology clinic to evaluate the effectiveness of corrections. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Discussion PH-14: *In all three records, a diagnosis of cancer was not found. In one record, an inmate self-reported a left nephrectomy due to renal cancer. There was no evidence of confirmatory testing and a CT report in the chart indicated that both kidneys were present, but one was atrophied. In another record, the diagnosis was idiopathic thrombocytopenic purpura or ITP. In the last record, there was no diagnosis indicated in the chart or on the problem list and the inmate was classified as an M-grade 1.*

Discussion PH-15: *In one record, an inmate with Hodgkin's Lymphoma had not seen a specialist since 2013. In the other record, an inmate with bladder cancer and multiple comorbidities had not seen a specialist in over one year. CMA surveyors noted these inmates may require services outside of the scope of the current treatment plan.*

Respiratory Clinic Record Review	
Finding(s)	**Suggested Corrective Action(s)**
PH-16: In 4 of 13 applicable records (16 reviewed), there was no evidence that reactive airway disease was classified as mild, moderate, or severe.	Provide in-service training to staff regarding the issue(s) identified in the Finding(s) column. Create a monitoring tool and conduct biweekly monitoring of no less than ten records of those enrolled in the respiratory clinic to evaluate the effectiveness of corrections. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Tuberculosis Clinic Record Review	
Finding(s)	**Suggested Corrective Action(s)**
PH-17: In 2 of 2 applicable records (8 reviewed), the inmate did not receive the correct doses of isoniazid (INH) medication (see discussion).	Provide in-service training to staff regarding the issue(s) identified in the Finding(s) column. Create a monitoring tool and conduct biweekly monitoring of no less than ten records of those enrolled in the tuberculosis clinic to evaluate the effectiveness of corrections. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Discussion PH-17: *In one record, the order for INH was written for "9 months" rather than for the number of doses needed. At the end of 9 months, however, the inmate had only received 70 doses. In the other record, the inmate received 75 doses. Per HSB 15.03.18, the appropriate treatment regimen is 78 doses to be given in nine months.*

Emergency Care Record Review	
Finding(s)	**Suggested Corrective Action(s)**
PH-18: In 7 of 18 records reviewed, there was no evidence of complete vital signs.	Provide in-service training to staff regarding the issue(s) identified in the Finding(s) column. Create a monitoring tool and conduct biweekly monitoring of no less than ten records of those receiving emergency care to evaluate the effectiveness of corrections. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Infirmary Record Review	
Finding(s)	**Suggested Corrective Action(s)**
A comprehensive review of 12 records revealed the following deficiencies: **PH-19: In 3 records, there was no evidence that all orders were received and implemented accordingly (see discussion).** **PH-20: In 6 records, there was no evidence of a complete nursing discharge note indicating patient's condition, disposition, patient education, and discharge instructions.** **PH-21: In 3 of 4 applicable records, there was no evidence of clinician weekend telephone rounds.**	Provide in-service training to staff regarding the issue(s) identified in the Finding(s) column. Create a monitoring tool and conduct biweekly monitoring of no less than ten records of inmates receiving infirmary services to evaluate the effectiveness of corrections. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Discussion PH-19: *In one record, five days of documentation was missing regarding foot soaks that were ordered. In another record, there was no evidence that padded side rails were provided as ordered. In the last record, an IV lock was ordered, but there was no evidence it was inserted, checked, or discontinued.*

Consultations Record Review	
Finding(s)	**Suggested Corrective Action(s)**
A comprehensive review of 16 records revealed the following deficiencies: **PH-22: In 16 records, the consultation log was incomplete.** **PH-23: In 7 records, the diagnosis was not recorded on the problem list.** **PH-24: In 3 of 13 applicable records, there was no evidence that the consultant's treatment recommendations were incorporated into the treatment plan.**	Provide in-service training to staff regarding the issue(s) identified in the Finding(s) column. Create a monitoring tool and conduct biweekly monitoring of no less than ten records of those receiving consultation services to evaluate the effectiveness of corrections. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Medication Administration	
Finding(s)	**Suggested Corrective Action(s)**
PH-25: In 1 of 1 applicable record (14 reviewed), medication was ordered and dispersed incorrectly (see discussion).	Provide in-service training to staff regarding the issue(s) identified in the Finding(s) column. Create a monitoring tool and conduct biweekly monitoring of no less than ten records of those receiving single dose medications to evaluate the effectiveness of corrections. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Discussion PH-25: *Tegretol was written twice on the order sheet. The medication administration record (MAR) indicated that each dose of the medication was subsequently given twice for a period of five days.*

Periodic Screenings	
Finding(s)	**Suggested Corrective Action(s)**
A comprehensive review of 15 records revealed the following deficiencies: **PH-26: In 7 records, the periodic screening was incomplete.** **PH-27: In 8 records, there was no evidence that all required diagnostic tests were performed prior to the screening (see discussion).**	Provide in-service training to staff regarding the issue(s) identified in the Finding(s) column. Create a monitoring tool and conduct biweekly monitoring of no less than ten records of those receiving periodic screenings to evaluate the effectiveness of corrections. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Discussion PH-27: *In three records, there was no evidence of a chest x-ray. Additionally, two of the three records did not contain an updated EKG since 2006 and 2011, respectively. In three records, there was no evidence of a urinalysis. Two of these records were also missing hemoccult information. In one record, there was not an EKG on file since 2013 and no record of hemoccult cards given. In the last record, there were no laboratory studies since 2015. HSB 15.03.04 states that a complete blood count and urinalysis by dipstick with results should be recorded in the chart, a random blood glucose by finger stick, if blood pressure reading is 135/80 or higher or the inmate has history of diabetes, an electrocardiogram if clinically indicated, an annual chest x-ray for inmates ages 55-77 with a smoking history, and stool hemoccult cards will be given to the inmate at the time lab work is drawn with instructions to return the cards at the time of the screening if the inmate is 50 years of age or older.*

Medical Inmate Requests	
Finding(s)	**Suggested Corrective Action(s)**
PH-28: In 9 of 17 records reviewed, a copy of the inmate request was not present in the chart (see discussion).	Provide in-service training to staff regarding the issue(s) identified in the Finding(s) column. Create a monitoring tool and conduct biweekly monitoring of no less than ten medical inmate requests to evaluate the effectiveness of corrections. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Discussion PH-28: *If the request is not in the record, it cannot be determined if the request was answered appropriately. Additionally, there were three inmate requests, found loose in two charts, that were not addressed or answered.*

Institutional Tour	
Finding(s)	**Suggested Corrective Action(s)**
A tour of the facility revealed the following deficiencies: **PH-29: Over-the-counter medications were not available in all dorms.** **PH-30: Procedures to access medical and dental sick call were not posted in confinement.** **PH-31: Pill line schedules were not posted in inmate common areas.**	Provide evidence in the closure file that the issues described have been corrected. This may be in the form of documentation, invoice, etc. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Additional Administrative Issues	
Finding(s)	**Suggested Corrective Action(s)**
PH-32: There was no evidence that appropriate infection control measures were in place (see discussion).	Provide in-service training to staff regarding the issue(s) identified in the Finding(s) column. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.
PH-33: Medical records were disorganized (see discussion).	Provide in-service training to staff regarding the issue(s) identified in the Finding(s) column. Create a monitoring tool and conduct biweekly monitoring of no less than ten applicable records to evaluate the effectiveness of corrections. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.
PH-34: Required logs were often incomplete or missing (see discussion).	Provide in-service training to staff regarding the issue(s) identified in the Finding(s) column. Create a monitoring tool and conduct biweekly monitoring of no less than ten

Additional Administrative Issues	
Finding(s)	**Suggested Corrective Action(s)**
	applicable records to evaluate the effectiveness of corrections. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.
PH-35: The DC4-770 series was incomplete or inaccurate for all clinic visits (see discussion).	Provide in-service training to staff regarding the issue(s) identified in the Finding(s) column. Create a monitoring tool and conduct biweekly monitoring of no less than ten applicable records to evaluate the effectiveness of corrections. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.
PH-36: The "Physician's Order Sheet" (DC4-714B) was used incorrectly (see discussion).	Provide in-service training to staff regarding the issue(s) identified in the Finding(s) column. Create a monitoring tool and conduct biweekly monitoring of no less than ten applicable records to evaluate the effectiveness of corrections. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Discussion PH-32: *The Infection Control Coordinator (ICC) had been in the position for five months and reported receiving no training. Staff stated during interviews, that she was not familiar with reporting requirements of infection control data. The ICC was not familiar with the procedures for issues regarding inmates with hepatitis or a suspected TB case. Staff indicated that sputum was not collected if a TB case was suspected.*

Discussion PH-33: *CMA surveyors noted that medical records were disorganized, with documentation frequently misfiled or missing altogether. Necessary documentation such as vaccination information, recent MARs, and inmate requests were often not in the chart and were unable to be located by staff. Progress notes were frequently filed out of chronological order.*

Discussion PH-34: *The "Infirmary Log" (DC4-797) and the "Grievance, Inmate Request or Inquiry Log" (DC4-797C) were not consistently kept. There were six patients on the infirmary log from March 2016 through May 2016, and only three of those had complete entries. Those who were on the log were 23 hour observation patients. Discussions with staff indicated that*

admitted infirmary patients were not logged. HSB 15.03.26 states that all patients are to be entered onto the log; DC4-797B for outpatients and DC4-797E for inpatients.
Pertinent information on the inmate request log including the disposition, answered by, and date returned to inmate column were consistently blank. HSB 15.02.01 states the Chief Health Officer/Institutional Medical Director or Health Services Administrator will designate a staff member to coordinate and maintain the log and files related to health care inquiries, requests, complaints, or informal grievances. A log is to be maintained, both in the medical unit and the mental health unit.

Discussion PH-35: *Per HSB 15.03.05 patients may be seen on a particular visit for multiple chronic illnesses. The physician or appropriate health care provider shall complete the specific flow sheet for each chronic illness clinic and shall document in narrative form on the "Chronic Illness Clinic" (DC4-701F). There is a specific flowsheet for each chronic illness clinic. Many of the flowsheets reviewed by surveyors; however, contained more than one diagnoses at the top of the form. This made it difficult to determine which diagnosis the clinician was referring to when answering the questions. For example, if the inmate was taking medication as prescribed or if he was compliant with treatment, it was not clear if he was compliant with all treatment or with one particular diagnostic treatment. Other flowsheets contained blanks and in others, entire visits were left off. Per Department policy, all forms are to be completed in their entirety and areas left blank without explanation are considered incomplete documentation.*

Discussion PH-36: *Per instructions on the DC4-714B there is to be no more than one order per line on the order sheet. Up to nine medications were written on order sheets with some appearing in the allergy section of the form making it difficult to read. Surveyors expressed concern that this could lead to errors in patient care.*

CONCLUSION

The physical health staff at BRCF serves a complex population. Of the almost 2000 inmates served, 963 are classified as either an M-grade 2 or 3, and 34 are physically impaired. Physical health care is provided on an inpatient and outpatient basis. In addition to providing routine physical health care and inmate education, medical staff participates in continuing education and infection control activities. Reportable findings requiring corrective action are outlined in the tables above.

Interviews conducted by surveyors and CMA staff indicated inmates were familiar with how to obtain routine medical and emergency services. Inmates expressed satisfaction with access to health care services, but expressed concern about getting their medications in a timely manner. An inspection of the medical areas revealed that they were adequately stocked and all areas on the compound were clean and neat.

CMA surveyors had difficulty obtaining the needed medical records throughout the survey. At times, it took institutional staff several hours to locate the necessary documentation. Some charts were not received until the afternoon of the second day which delayed the survey process.

Several concerns were identified in the provision of clinical services. Records were frequently missing vaccination information, fundoscopic examinations, and referrals to specialists when indicated. Orders were not consistently being implemented as received in the infirmary, and some inmates enrolled in the tuberculosis clinic were not receiving the correct number of doses of INH medication for treatment of latent infection.

In addition to clinical issues, three tracking issues were also identified during the survey. One issue was identified in the area of consultations. BRCF was not using the Department's consultation log; therefore, pertinent information such as the date the request was made, the outcome of the consultation, and if follow-up or additional tests were needed was unavailable. The second issue was in the area of medication receipt. As mentioned above, several inmates reported to CMA staff that they had difficulty getting their medications. The majority of inmates at BRCF receive their medications as keep-on-person (KOP). Staff was aware of this problem and has worked to create a tracking system in which the signed KOP receipt will either be placed in the chart or in a notebook. This process had just recently been implemented; however, as of the time of the survey, the collected signature pages were neither in a notebook nor in the chart, but were available for surveyors to look through. While nursing staff is responsible for ensuring that inmates sign for KOP medication, there was often no documentation in the medical record to indicate that an ordered medication was KOP. The third issue concerned the lack of infirmary logs and inmate request logs and both are discussed in the table above. Logs are an important tracking tool when used correctly and provide an "at a glance" look at the medical services being provided.

BRCF has recently undergone many changes in personnel and staffing, including several key positions. The Health Services Administrator and the Director of Nursing came on board in April 2016. There were four RN and two LPN vacancies at the time of the survey. Two of the nurses interviewed by the CMA had only been in their positions five days and three weeks, respectively. The Clinical Associate resigned and left two weeks prior to the survey. CMA clinical surveyors expressed concern that the current environment of personnel vacancies, turnover in leadership positions, and a lack of organizational structures could lead to adverse health outcomes for inmates.

Based on the findings of this survey and discussions above, it is clear that the CMA corrective action process will be beneficial to BRCF as they strive to meet the health care needs of the inmate population and improve care in areas that were found to be deficient.

MENTAL HEALTH FINDINGS

Blackwater River Correctional Facility (BRCF) provides outpatient mental health services. The following are the mental health grades used by the department to classify inmate mental health needs at BRCF:

- S1 - Inmate requires routine care (sick call or emergency).
- S2 - Inmate requires ongoing services of outpatient psychology (intermittent or continuous).
- S3 - Inmate requires ongoing services of outpatient psychiatry (case management, group, and/or individual counseling, as well as psychiatric or psychiatric ARNP care).

CLINICAL RECORDS REVIEW

SELF INJURY/SUICIDE PREVENTION REVIEW

There were findings requiring corrective action in the review of Self-harm Observation Status (SHOS); the items to be addressed are indicated in the table below. There were no episodes of restraints at BRCF.

USE OF FORCE REVIEW

There were findings requiring corrective action in the review of use of force episodes; the items to be addressed are indicated in the table below.

ACCESS TO MENTAL HEALTH SERVICES REVIEW

There were no findings requiring corrective action in the review of psychological emergencies. There were findings requiring corrective action in the review of inmate requests and special housing; the items to be addressed are indicated in the tables below.

OUTPATIENT SERVICES REVIEW

There were findings requiring corrective action in the review of outpatient mental health services and psychiatric medication practices; the items to be addressed are indicated in the tables below.

AFTERCARE PLANNING REVIEW

There were findings requiring corrective action in the review of aftercare planning; the items to be addressed are indicated in the table below.

MENTAL HEALTH SYSTEMS REVIEW

There were findings requiring corrective action in the review of mental health systems; the items to be addressed are indicated in the table below.

Self-harm Observation Status (SHOS)	
Finding(s)	**Suggested Corrective Action(s)**
A comprehensive review of 15 Self-harm Observation Status (SHOS) admissions revealed the following deficiencies: **MH-1: In 10 records, an emergency evaluation was not completed by mental health or nursing staff prior to an SHOS admission (see discussion).** **MH-2: In 3 records, SHOS orders were not cosigned by the next working day or were incomplete (see discussion).** **MH-3: In 10 records, the "Infirmary/Hospital Admission Nursing Evaluation" (DC4-732) was not completed within 2 hours of an SHOS admission (see discussion).** **MH-4: In 1 of 2 applicable records, the guidelines for SHOS management were not observed (see discussion).** **MH-5: In 8 records, documentation did not indicate the inmate was observed at the frequency ordered by the clinician (see discussion).** **MH-6: In 8 records, the "Inpatient Mental Health Daily Nursing Evaluation" (DC4-673B) was not completed once per shift.** **MH-7: In 4 of 14 applicable records, the attending clinician did not conduct a face-to-face evaluation prior to discharge or the evaluation was clinically inappropriate (see discussion).** **MH-8: In 8 of 14 applicable records, mental health staff did not provide post-discharge follow-up within 7 days (see discussion).** **MH-9: In 9 records, not all entries were dated, timed, signed and/or stamped.**	Provide in-service training to staff regarding the issue(s) identified in the Finding(s) column. Create a monitoring tool and conduct biweekly monitoring of no less than ten SHOS admissions to evaluate the effectiveness of corrections. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Discussion MH-1: *In four records, there was no indication an emergency evaluation was completed. In two records, the form was incomplete and did not address all required areas. In the remaining four records, the proper form was not present and a SOAP note, incidental note, or progress note was used instead. By not using the correct form, information is excluded due to the lack of prompts that are provided on the "Mental Health Emergency Evaluation" or "Mental Health Emergency Nursing Assessment" (DC-642-G or D- 683A respectively).*

Discussion MH-2: *In two records, the telephone order was not cosigned by the clinician on the next business day and remained absent at the time of the survey. The last record included an order without a date or time.*

Discussion MH-3: *In seven records, the form was present but incomplete. In the remaining three records, there was no evidence that this evaluation occurred.*

Discussion MH-4: *According to the Department's HSB, during the fourth day of infirmary mental health care, the attending clinician will, after personally evaluating the inmate, determine whether at that point, crisis stabilization care will be needed to resolve the mental health crisis. The documentation established that the inmate requested admission to a higher level of care but there was no indication this was considered.*

Discussion MH-5: *Physician's orders indicated 15 minute observations for inmates admitted to SHOS. These observations were documented on "Observation Checklist" (DC4-650). In five records, there were one or more blanks on the checklist indicating the inmate was not observed as required. In the remaining three records, staff members did not initial and sign the form to indicate who performed the observations.*

Discussion MH-7: *In three records, there was no evidence that this evaluation occurred. In the last record, an inmate took an overdose of 15-20 Vistaril. Two days later the clinician indicated that since the inmate had a history of "cheeking" medications, he would be discharged to confinement. A nursing note written an hour prior to the discharge order indicated the inmate still wanted to die. The clinician's discharge assessment did not address the nurse's note, current suicidal ideations, or self-harm behaviors. He was subsequently readmitted to SHOS 13 days later.*

Discussion MH-8: *In two records, follow-up with mental health staff was not completed timely. In the remaining six records, there was no indication that follow-up occurred by the time of the survey.*

Use of Force	
Finding(s)	**Suggested Corrective Action(s)**
A comprehensive review of 8 use of force episodes revealed the following deficiencies: **MH-10: In 2 of 7 applicable records, a written referral to mental health by physical health staff was not present (see discussion).**	Provide in-service training to staff regarding the issue(s) identified in the Finding(s) column. Create a monitoring tool and conduct biweekly monitoring of no less than ten use of force episodes to evaluate the effectiveness of corrections.

Use of Force	
Finding(s)	**Suggested Corrective Action(s)**
MH-11: In 2 of 7 applicable records, there was no indication that mental health staff interviewed the inmate the next working day to determine the level of mental health care needed.	Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Discussion MH-10: *According to Florida Administrative Code (Rule 33-602.210, F.A.C.), attending medical staff members shall make a mental health referral for any inmate who is exposed to chemical agents and classified as S2 or S3.*

Inmate Requests	
Finding(s)	**Suggested Corrective Action(s)**
A comprehensive review of 15 inmate requests revealed the following deficiencies:	Provide in-service training to staff regarding the issue(s) identified in the Finding(s) column.
MH-12: In 3 records, a copy of the inmate request form was not present (see discussion).	Create a monitoring tool and conduct biweekly monitoring of no less than ten inmate requests to evaluate the effectiveness of corrections.
MH-13: In 3 of 12 applicable records, the identified request was not responded to within appropriate time frame (see discussion).	Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Discussion MH-12: *If the request is not in the record, it cannot be determined if the request was answered appropriately.*

Discussion MH-13*: Inmate-initiated requests will be responded to within ten working days. Dating, timing, signing, and stamping documents related to the inmate request and subsequent response is important in maintaining these deadlines. The inmate request log showed receipt and response on the same day for all entries. Surveyors utilized the date listed on the mental health log in the absence of the received date. This made it difficult to assess if the requests were responded to within the required time frame. The majority of the requests found in the records were not stamped when received; therefore, it is unclear as to how many days lapsed between when the request was written, submitted, and a response given.*

Special Housing	
Finding(s)	**Suggested Corrective Action(s)**
A comprehensive review of 11 records of inmates in special housing revealed the following deficiencies: **MH-14: In 6 records, the "Special Housing Health Appraisal" (DC4-769) was incomplete or missing.** **MH-15: In 3 of 10 applicable records, psychotropic medications ordered were not continued as directed while the inmate was held in special housing (see discussion).** **MH-16: In 7 records, initial mental status exams (MSE) were not completed within the required time frame (see discussion).** **MH-17: In 2 of 6 applicable records, outpatient treatment did not continue as indicated on the Individualized Service Plan (ISP) while the inmate was in special housing.**	Provide in-service training to staff regarding the issue(s) identified in the Finding(s) column. Create a monitoring tool and conduct monthly monitoring of no less than ten records of inmates in special housing to evaluate the effectiveness of corrections. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Discussion MH-15: *Health Services Bulletin (HSB 15.05.08) indicates that when an inmate is in confinement and has an active prescription for psychotropic medication, staff is to ensure that the medication continues to be available during his/her stay. In all three records, there was no indication that the medication(s) were offered or refused as evidenced by blanks on the MAR and the absence of a signed refusal.*

Discussion MH-16: *The Department's HSB states that each inmate who is classified as S3 and who is assigned to administrative or disciplinary confinement, protective management, or close management status shall receive a MSE within five days of assignment and every 30 days thereafter. Each inmate who is classified as S1 or S2 and who is assigned to administrative or disciplinary confinement, protective management, or close management status shall receive a MSE within 30 days and every 90 days thereafter. In four records, the MSE was completed in greater than five days. In two records, the documentation indicated that the inmate refused the exam but there was not an accompanying incidental note and refusal form. In the last record, the exam was present but the inmate statement and plan were blank.*

Outpatient Psychotropic Medication Practices	
Finding(s)	**Suggested Corrective Action(s)**
A comprehensive review of 18 outpatient records revealed the following deficiencies: **MH-18: In 1 of 2 applicable records, a thorough psychiatric evaluation was not completed prior to initiating treatment with psychotropic medications.** **MH-19: In 5 of 16 applicable records, appropriate initial laboratory tests were not ordered for psychotropic medications (see discussion).** **MH-20: In 4 of 9 applicable records, there was no evidence that abnormal lab results were addressed (see discussion).** **MH-21: In 8 of 13 applicable records, follow-up lab tests were not completed as required (see discussion).** **MH-22: In 5 records, the inmate did not receive medications as prescribed and documentation of refusal was not present in the medical record.** **MH-23: In 12 records, follow-up psychiatric contacts were not conducted at appropriate intervals (see discussion).** **MH-24: In 7 of 17 applicable records, documentation of follow-up psychiatric contacts did not contain the required clinical information (see discussion).** **MH-25: In 2 of 9 applicable records, Abnormal Involuntary Movement Scales (AIMS) were not administered within the appropriate time frame.**	Provide in-service training to staff regarding the issue(s) identified in the Finding(s) column. Create a monitoring tool and conduct biweekly monitoring of no less than ten applicable outpatient records to evaluate the effectiveness of corrections. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Discussion MH-19: *In three records, the Complete Metabolic Panel (CMP) was non-fasting. In one record, lab tests for Thyroid-Stimulating Hormone (TSH) had not been done since August 2014. In the last record, the inmate had a history of leukopenia, thrombocytopenia, and neutropenia, which was not addressed prior to starting Tegretol.*

Discussion MH-20: *In one record, an abnormal lab from 8/11/14 received no follow-up by the time of the survey. In two records, there was no follow-up for elevated TSH levels despite continued symptoms of depression. In the last record, there was no indication of follow-up for elevated blood glucose.*

Discussion MH-21: *In three records, there was no lipid profile ordered. In two records, TSH was not addressed. In one record, there was no mention of a non-fasting blood glucose or consideration of repeating this screening. In the last record, the Valproic Acid level was not ordered during the first two months of treatment. It was then ordered on 5/23/16, but was still pending at the time of the survey.*

Discussion MH-23: *In four records, there was greater than 90 days between psychiatric contacts. In the remaining eight records, follow-up occurred between four and nine months after the previous appointment.*

Discussion MH-24: *In three records, documentation was incomplete on portions of the form. In the remaining four records, vital information, such as abnormal labs, alternative medications, symptoms of psychosis, or evaluation of suicidal ideation, was omitted.*

Outpatient Mental Health Services	
Finding(s)	**Suggested Corrective Action(s)**
A comprehensive review of 18 outpatient records revealed the following deficiencies: **MH-26: In 4 of 17 applicable records, the "Health Information Arrival/Transfer Summary" (DC4-760A) was not completed within 24 hours of arrival to the facility.** **MH-27: In 6 of 17 applicable records, the initial mental health screening evaluation or Individualized Service Plan (ISP) was not updated (see discussion).** **MH-28: In 2 of 3 applicable records, the sex offender screening was not completed.** **MH-29: In 4 of 4 applicable records, the consent for sex offender treatment was not signed or a refusal was not documented.** **MH-30: In 1 of 4 applicable records, the ISP was not completed timely when the inmate was changed from S2 to S3 grade.**	Provide in-service training to staff regarding the issue(s) identified in the Finding(s) column. Create a monitoring tool and conduct biweekly monitoring of no less than ten applicable outpatient records to evaluate the effectiveness of corrections. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Outpatient Mental Health Services	
Finding(s)	**Suggested Corrective Action(s)**
MH-31: In 7 of 17 applicable records, the ISP was not signed by a member of the multidisciplinary services team (MDST) and/or inmate or a refusal was not documented (see discussion). **MH-32: In 6 of 15 applicable records, the ISP was not revised within 180 days.** **MH-33: In 6 records, mental health problems were not recorded on the problem list.** **MH-34: In 7 of 16 applicable records, there was a lack of documentation that the inmate received the mental health interventions and services described in the ISP (see discussion).** **MH-35: In 5 of 7 applicable records, counseling was not provided to inmates with a diagnosis of Schizophrenia or other psychotic disorders at least once every 30 days or a refusal was not present.** **MH-36: In 4 records, case management was not provided at least every 90 days.** **MH-37: In 4 records, the frequency of clinical contacts was insufficient or not clinically appropriate.**	

Discussion MH-27: *In one record, the form was present but incomplete. In the remaining five records, there was no evidence that the Mental Health Screening Evaluation or ISP update was completed.*

Discussion MH-31*: In two records, the inmate's signature was missing and there was no documentation of refusal. In the remaining five records, a signature was missing from a member of the MDST.*

Discussion MH-34*: In two records, inmates were not seen for case management and counseling every 30 days as indicated on the ISP. In three records, inmates were not seen every 90 days as indicated on the ISP. In two records, there was no evidence these services were ever provided.*

Aftercare Planning	
Finding(s)	**Suggested Corrective Action(s)**
A comprehensive review of 12 records of S3 inmates within 180 days end of sentence (EOS) revealed the following deficiencies: **MH-38: In 4 records, aftercare plans were not addressed on the ISP for inmates within 180 days of EOS.** **MH-39: In 6 of 11 applicable records, consent to release information for continuity of care was missing or incomplete.** **MH-40: In 2 of 2 applicable records, assistance with Social Security benefits was not provided.**	Provide in-service training to staff regarding the issue(s) identified in the Finding(s) column. Create a monitoring tool and conduct biweekly monitoring of no less than ten applicable records of inmates within 180 days EOS to evaluate the effectiveness of corrections. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Additional Administrative Issues	
Finding(s)	**Suggested Corrective Action(s)**
MH-41: There was no documentation that the MDST meets on a regularly scheduled basis.	Provide evidence in the closure file that the issue described has been corrected. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.
MH-42: There was no documentation that one hour of accrued clinical supervision was provided to each mental health professional weekly.	Provide evidence in the closure file that the issue described has been corrected. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.
MH-43: There is an inadequate tracking mechanism to reflect mental health related admissions and discharges from the infirmary (see discussion).	Provide in-service training to staff regarding the issue(s) identified in the Finding(s) column. Create a monitoring tool and conduct biweekly monitoring of the Psychological Emergency and SHOS log for accuracy and legibility.

Additional Administrative Issues	
Finding(s)	**Suggested Corrective Action(s)**
	Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.
MH-44: There was no restraint or self-harm prevention equipment for the inmate population (see discussion).	Provide evidence in the closure file that the issue described has been corrected. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.
MH-45: Medical records were disorganized and incomplete, making it difficult to establish adequate standards of care (see discussion).	Include documentation in the closure file that appropriate in-service training has been provided to staff regarding the issues in the Finding(s) column. Monitor a minimum of ten records weekly for compliance. Monitoring intervals may be modified to less often if the results indicate appropriate compliance or correction. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Discussion MH-43: *According to department policy (404.001) mental health staff will record the emergency referral on the "Mental Health Emergency, Self-harm, SHOS/MHOS Placement Log" (DC4-781A). The documentation on the log did not include a presenting problem or a disposition making it difficult to determine if the inmate received the appropriate referral or level of care after a psychological emergency. Additionally this log did not contain admissions to SHOS.*

Discussion MH-44: *According to HSB 15.05.10, the health services administrator shall ensure that the following equipment is available and in good working condition. Two or more sets of wrist and leg restraints and one protective helmet in each size e.g. small, medium, and large.*

Discussion MH-45: *In many records, documents were out of order or were missing altogether. Additionally, some records contained loose filing and some records were in a state of disrepair. Metal prongs that secure documents to the folder were no longer intact, and many of these records needed to be thinned. A few records contained documents pertaining to other inmates.*

CONCLUSION

The staff at BRCF serves a difficult population that includes inmates with multiple medical and psychiatric comorbidities. In addition to providing services to inmates on the mental health caseload, staff answer inmate requests, respond to psychological emergencies, and perform weekly rounds in confinement. Staff also perform sex offender screenings when needed, provide aftercare planning for eligible inmates, and provide daily counseling for inmates in SHOS. Reportable findings requiring corrective action are outlined in the tables above.

CMA surveyors noted several areas in which the provision of clinical services were found to be deficient. The lack of organization in the medical records was problematic, and was most notable in the haphazard arrangement of forms and disrepair of charts. Additionally, the clinical surveyors had difficulty in obtaining the needed medical records throughout the survey.

There were concerns with the frequency of clinical contacts for inmates on the mental health caseload. Inmates were not consistently evaluated by mental health staff, including psychiatry, within the required time frame, and there were multiple examples of inmates not receiving the services outlined on their treatment plans. Inmates indicated in interviews that they often do not receive their scheduled case management, therapy, or psychiatric visits. They reported the need to sometimes “go psych” or declare a psychological emergency in order to be seen by mental health staff.

There were also many findings related to missing, incomplete, and inaccurate assessments. For example, nursing assessments in SHOS and special housing were often incomplete, late, or missing. Individualized Service Plans were frequently incomplete or not completed timely. Sex offender screenings were not performed as required, inmates were not consistently seen after a use of force episode, and the requirements for aftercare planning for inmates nearing the end of their sentences were not met. These assessments are crucial in determining the proper course of treatment for inmates in need of mental health services

Medical records reviewed for psychotropic medications and special housing did not consistently contain documentation of the daily administration of medication. There were gaps in the medication administration record (MAR) indicating that medication was not administered for that day. Surveyors were concerned that inmates on mental health medications (especially those requiring titration) who do not receive medications as prescribed may experience adverse physical or psychological effects. In addition to the administration of medication, initial and follow-up labs were not performed as required and abnormal labs were not addressed.

In addition to clinical findings there were some administrative issues noted. As discussed earlier inmate request and psychological emergency/SHOS logs were inaccurate. There was no documentation that the MDST met as required or mental health professionals were receiving supervision. Medical records were disorganized with pages misfiled or missing altogether. This disorganization also made it difficult for experienced clinical surveyors to follow the course of treatment. Disorganized medical records can lead to medical errors and disrupt continuity of care.

The staff interviewed were knowledgeable and presented a genuine concern for the inmates on their caseload. They were receptive to feedback from surveyors and expressed a desire to correct the deficiencies noted. Staff indicated they were aware of many of the findings discovered during the review and were taking steps to ensure these issues are corrected. After

a review of mental health records and interviews with staff and inmates and based on the findings listed above, it is clear that the BRCF will benefit from the CMA corrective action plan process.

SURVEY PROCESS

The goals of every survey performed by the CMA are:

1) to determine if the physical, dental, and mental health care provided to inmates in all state public and privately operated correctional institutions is consistent with state and federal law, conforms to standards developed by the CMA, is consistent with the standards of care generally accepted in the professional health care community at large;
2) to promote ongoing improvement in the correctional system of health services; and,
3) to assist the Department in identifying mechanisms to provide cost effective health care to inmates.

To achieve these goals, specific criteria designed to evaluate inmate care and treatment in terms of effectiveness and fulfillment of statutory responsibility are measured. They include determining:

- If inmates have adequate access to medical and dental health screening and evaluation and to ongoing preventative and primary health care.
- If inmates receive adequate and appropriate mental health screening, evaluation and classification.
- If inmates receive complete and timely orientation on how to access physical, dental, and mental health services.
- If inmates have adequate access to medical and dental treatment that results in the remission of symptoms or in improved functioning.
- If inmates receive adequate mental health treatment that results in or is consistent with the remission of symptoms, improved functioning relative to their current environment and reintegration into the general prison population as appropriate.
- If inmates receive and benefit from safe and effective medication, laboratory, radiology, and dental practices
- If inmates have access to timely and appropriate referral and consultation services.
- If psychotropic medication practices are safe and effective.
- If inmates are free from the inappropriate use of restrictive control procedures.
- If sufficient documentation exists to provide a clear picture of the inmate's care and treatment.
- If there are sufficient numbers of qualified staff to provide adequate treatment.

To meet these objectives, the CMA contracts with a variety of licensed community and public health care practitioners, such as physicians, psychiatrists, dentists, nurses, psychologists, and licensed mental health professionals. The survey process includes a review of the physical, dental and mental health systems; specifically, the existence and application of written policies and procedures, staff credentials, staff training, confinement practices, and a myriad of additional administrative issues. Individual case reviews are also conducted. The cases selected for review are representative of inmates who are receiving mental and/or physical health services (or who are eligible to receive such services).

Conclusions drawn by members of the survey team are based on several methods of evidence collection:

- Physical evidence – direct observation by members of the survey team (tours and observation of evaluation/treatment encounters)

- Testimonial evidence – obtained through staff and inmate interviews (and substantiated through investigation)
- Documentary evidence – obtained through reviews of medical/dental records, treatment plans, schedules, logs, administrative reports, physician orders, service medication administration reports, meeting minutes, training records, etc.
- Analytical evidence – developed by comparative and deductive analysis from several pieces of evidence gathered by the surveyor

Administrative (system) reviews generally measure whether the institution has policies in place to guide and direct responsible institutional personnel in the performance of their duties and if those policies are being followed. Clinical reviews of selected inmate medical, dental and mental health records measure if the care provided to inmates meets the statutorily mandated standard. Encounters of an episodic nature, such as sick call, an emergency, an infirmary admission, restraints, or a suicide episode, as well as encounters related to a long-term chronic illness or on-going mental health treatment are also reviewed. Efforts are also made to confirm that administrative documentation (e.g., logs, consultation requests, medication administration reports, etc.) coincides with clinical documentation.

Findings identified as a result of the survey may arise from a single event or from a trend of similar events. They may also involve past or present events that either had or may have the potential of compromising inmate health care. All findings identified in the body of the report under the physical or mental health sections require corrective action by institutional staff.