CORRECTIONAL MEDICAL AUTHORITY

PHYSICAL & MENTAL HEALTH SURVEY

of

Taylor Correctional Institution

in

Perry, Florida

on

January 15 – 16, 2014

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DEMOGRAPHICS

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

INSTITUTIONAL INFORMATION			
Population	**Type**	**Custody Level**	**Medical Level**
3,250	**Male**	**Close**	**4**

Institutional Potential/Actual Workload

Main Unit Capacity	**1,421**	**Current Main Unit Census**	**1,422**
Annex Capacity	**1,291**	**Current Annex Census**	**1,220**
Satellite Unit(s) Capacity	**432**	**Current Satellite(s) Census**	**428**
Total Capacity	**3,144**	**Total Current Census**	**3,070**

Inmates Assigned to Medical/Mental Health Grades

Medical Grade	***1***	***2***	***3***	***4***	***5***	***Impaired***
	2,117	**531**	**589**	**6**	**0**	**0**
Mental Health Grade (S-Grade)	***Mental Health Outpatient***			***MH Inpatient***		
	1	***2***	***3***	***4***	***5***	***Impaired***
	3,136	**107**	**0**	**0**	**0**	**0**

Inmates Assigned to Special Housing Status

Confinement/ Close Management	***DC***	***AC***	***PM***	***CM3***	***CM2***	***CM1***
	219	**126**	**0**	**0**	**0**	**0**

DEMOGRAPHICS

Medical Staffing: Main Unit

	Number of Positions	Number of Vacancies
Physician	1	0
Clinical Associate	.5	0
RN	3	1
LPN	8.5	0
CMT-C	2.4	0

Medical Staffing: Annex

	Number of Positions	Number of Vacancies
Physician	1	0
Clinical Associate	.5	.5
RN	4.2	3.2
LPN	8.2	.2
CMT-C	1	1

Mental Health Staffing: Main Unit and Annex

	Number of Positions	Number of Vacancies
Senior Mental Health Clinician	1	1
Mental Health Professional	2	1

OVERVIEW

Taylor Correctional Institution (TAYCI) houses male inmates of minimum, medium, and close custody levels. The facility grades are medical (M) grades 1, 2, 3, and 4 and psychology (S) grades 1 and 2. TAYCI consists of the Main Unit and an Annex.

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

The Correctional Medical Authority (CMA) conducted a thorough review of the medical, mental health, and dental systems at TAYCI on January 15-16, 2014. 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.

Corizon took over operation of health care from the Department on September 15, 2013 at a time when there were vacancies in key staff positions at TAYCI. The roles of Health Services Administrator, Senior Nursing Supervisor and Senior Mental Health Clinician had been vacant for at least five months prior to Corizon's takeover. Although these positions were covered by staff from neighboring institutions when possible, there was no one dedicated to providing these vital leadership functions solely at Taylor CI. This void in leadership and staffing issues has resulted in serious concerns regarding the provision of care at this institution. Additionally, a general lack of organization has resulted in multiple instances of medical problems not being followed and resolved.

Corizon recently hired a Health Services Administrator and Senior Nursing Supervisor; however these positions had only been filled a short time prior to the survey. A Senior Mental Health Clinician had recently been approved for hire as well. The CMA is hopeful that with the filling of these key positions, changes will be implemented to ensure the issues identified in this report will not become increasingly chronic and serious. Depending on the results of the corrective action plan produced in response to this report, the CMA may re-survey TAYCI 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 – MAIN UNIT

Taylor Correctional Institution-Main (TAYCI-Main) provides outpatient and inpatient physical health services. The following are the medical grades used by the Department to classify inmate physical health needs at TAYCI-Main:

- 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.
- M4 - Inmate is being followed in a CIC every three months and requires ongoing visits to the physician more often than every three months.

CLINICAL RECORDS REVIEW

CHRONIC ILLNESS RECORD REVIEW

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

EPISODIC CARE REVIEW

There were findings requiring corrective action in the review of infirmary care and sick call. There were no findings requiring corrective action in the review of emergency care.

OTHER MEDICAL RECORD REVIEW

There were findings requiring corrective action in the review of consultations, medication administration, periodic screenings, and intra-system transfers; 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 infection control. There were findings requiring corrective action in the review of pharmacy services and the administration of the pill line.

INSTITUTIONAL TOUR

There were findings requiring corrective action as a result of the institutional tour.

Cardiovascular Clinic Record Review	
Finding(s)	**Suggested Corrective Action(s)**
PH-1: A comprehensive review of 17 inmate records revealed the following deficiencies (see discussion): **(a) In 5 records, the baseline physical examination was incomplete or missing.** **(b) In 4 records, the baseline laboratory work was incomplete or missing.**	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. Monitoring intervals may be modified to less often if results indicate appropriate compliance or correction. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Discussion PH-1: *Baseline history, physical examination, and baseline laboratory data was frequently missing from the current Chronic Illness Clinic Flowsheets (DC4-770). Per policy (Health Services Bulletins 15.12.03 and 15.03.05), the DC4-770 series must be completed in its entirety. When the flowsheet is incomplete or previous sheets removed from the inmate's record, it may be difficult to obtain an adequate understanding of the inmate's complete medical history. Although addressed here, this baseline information was missing from several of the other clinics as indicated in the tables below.*

Endocrine Clinic Record Review	
Finding(s)	**Suggested Corrective Action(s)**
PH-2: A comprehensive review of 15 inmate records revealed the following deficiencies: **(a) In 10 records, there was no evidence of an annual dilated fundoscopic examination (see discussion).** **(b) In 6 of 11 applicable records, there was no evidence of pneumococcal vaccine or refusal.** **(c) In 9 of 10 applicable records, there was no evidence of influenza vaccine or refusal.** **(d) In 3 records, the Chronic Illness Clinic (CIC) forms and progress notes**	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. Monitoring intervals may be modified to less often if results indicate appropriate compliance or correction. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Endocrine Clinic Record Review	
Finding(s)	**Suggested Corrective Action(s)**
were not completed, legible, dated, timed, signed, and/or signature stamped.	

Discussion PH-2(a): *Health Services Bulletin 15.03.05 states that a dilated fundoscopic examination will be done annually.*

Gastrointestinal Clinic Record Review	
Finding(s)	**Suggested Corrective Action(s)**
PH-3: A comprehensive review of 13 inmate records revealed the following deficiencies: **(a) In 5 records, the baseline history was incomplete or missing.** **(b) In 10 records, the baseline physical examination was incomplete or missing.** **(c) In 8 records, the baseline laboratory work was incomplete or missing.** **(d) In 3 records, the baseline assessment did not indicate control of the disease.** **(e) In 5 of 8 applicable records, there was no evidence of influenza vaccine or refusal.** **(f) In 5 of 11 applicable records, hepatitis A & B vaccine was not given to inmates with hepatitis C infection and no prior history of A & B infection.**	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. Monitoring intervals may be modified to less often if results indicate appropriate compliance or correction. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Immunity Clinic Record Review	
Finding(s)	**Suggested Corrective Action(s)**
PH-4: A comprehensive review of 13 inmate records revealed the following deficiencies: **(a) In 8 of 12 applicable records, there was no evidence of hepatitis B vaccine or refusal (see discussion).** **(b) In 5 records, there was no evidence of pneumococcal vaccine or refusal.** **(c) In 3 records, HIV medications (Intelence, Prezista, and Isentress) were consistently out of stock (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. Monitoring intervals may be modified to less often if results indicate appropriate compliance or correction. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Discussion PH-4(a): *Health Services Bulletin 15.03.30 states that inmates who have evidence of HIV infection and no evidence of past hepatitis B infection should be given the hepatitis B vaccination.*

Discussion PH-4(c): *In one record Intelence was out of stock 7/16/13-7/26/13, Prezista 7/22/13-7/26/13, and Isentress 7/10/13-7/14/13. Intelence and Prezista were also out of stock 8/27/13- 9/6/13. In another record Isentress and Prezista were out of stock 4/5/13-4/9/13, 7/24/13-7/26/13, 8/23, and 4 days in September 2013. In the third record, the medications were out of stock from 9/10-16/13. Surveyors expressed concern that missing doses or interrupting treatment could make the drugs less effective and increase the possibility of drug resistance. This institution participates in the 340B Program through the Department of Health. Although the inmate is evaluated and treated by DOH staff, clerical aspects of the program are the responsibility of the institutional medical staff. Per the nursing manual, nursing staff are to fax the DOH 340B program prescriptions to their assigned regional pharmacy prior to the prescription form being filed in the medical charts. The DOH Central Pharmacy will then mail all patient specific prescriptions for inmates to the institution. Health care was provided by the Department the majority of the days these medications were missed, however due to the critical nature of this finding; surveyors felt this process should be monitored to prevent missed dosages of important medications.*

Miscellaneous Clinic Record Review	
Finding(s)	**Suggested Corrective Action(s)**
PH-5: In 1 of 4 applicable records (7 reviewed), there was no evidence of pneumococcal vaccine 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 applicable records to evaluate the effectiveness of corrections. Monitoring intervals may be modified to less often if results indicate appropriate compliance or correction. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Neurology Clinic Record Review	
Finding(s)	**Suggested Corrective Action(s)**
PH-6: A comprehensive review of 10 inmate records revealed the following deficiencies: **(a) In 2 records, the baseline history was incomplete or missing.** **(b) In 1 of 4 applicable records, there was no evidence of pneumococcal vaccine or refusal.** **(c) In 2 records, the CIC forms and progress notes were not completed, legible, dated, timed, signed and/or signature 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 applicable records to evaluate the effectiveness of corrections. Monitoring intervals may be modified to less often if results indicate appropriate compliance or correction. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Oncology Clinic Record Review	
Finding(s)	**Suggested Corrective Action(s)**
PH-7: A comprehensive review of 5 inmate records revealed the following deficiencies: **(a) In 2 records, the baseline history was incomplete or missing.** **(b) In 2 records, the baseline physical examination was incomplete or missing.** **(c) In 1 record, the baseline laboratory work was incomplete or missing.** **(d) In 1 record, the appropriate baseline marker studies were not obtained.**	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. Monitoring intervals may be modified to less often if results indicate appropriate compliance or correction. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Respiratory Clinic Record Review	
Finding(s)	**Suggested Corrective Action(s)**
PH-8: A comprehensive review of 13 inmate records revealed the following deficiencies: **(a) In 3 records, the diagnosis was not accurately recorded on the problem list.** **(b) In 3 records, the baseline physical exam was incomplete or missing.** **(c) In 5 records, there was no evidence of a peak flow reading at each CIC visit (see discussion).** **(d) In 3 of 12 applicable records, there was no documentation indicating the control of the disease and/or patient status (see discussion).** **(e) In 3 of 7 applicable records, there was no evidence of pneumococcal vaccine or refusal.** **(f) In 7 records, the CIC forms and**	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. Monitoring intervals may be modified to less often if results indicate appropriate compliance or correction. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Respiratory Clinic Record Review	
Finding(s)	**Suggested Corrective Action(s)**
progress notes were not completed, legible, dated, timed, signed and/or signature stamped.	

Discussion PH-8(c & d): *Health Services Bulletin 15.03.05 states that a peak flow reading and an evaluation as to the control of the disease will be recorded at each visit. In the five records reviewed where the peak flow recording was missing, three of the charts had CIC flowsheets with incomplete information, while the other two records did not have CIC flowsheets. In the three records regarding the control of the disease and status of the patient, two CIC flowsheets were incomplete and one was missing altogether. Surveyors indicated having the peak flow reading in combination with the control of the disease and status of the patient were important in providing an "at a glance" look at the inmate's progression or regression.*

Sick Call Clinic Record Review	
Finding(s)	**Suggested Corrective Action(s)**
PH-9: A comprehensive review of 16 inmate records revealed the following deficiencies: **(a) In 3 of 15 applicable records, there was no evidence of completed vital signs.** **(b) In 7 records, there was no evidence of patient education applicable to the presenting complaint.** **(c) In 2 of 10 applicable records, there was no evidence that follow-up appointments were initiated and/or completed in a timely manner.** **(d) In 2 of 10 applicable records, there was no evidence that the clinician's orders from the follow-up visit were adequately completed (see discussion).** **(e) In 2 of 10 applicable records, the follow-up health care provider's documentation was not completed, legible, and/or timely.**	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. Monitoring intervals may be modified to less often if results indicate appropriate compliance or correction. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Discussion PH-9(d): *In one record, the nurse's SOAPE note addressed the inmate's condition of a rash/fungus. Directly under that note, the clinician wrote "above reviewed, not seen". The clinician's note was not dated or timed. In the other record, the inmate presented to sick call with*

urinary complaints. The clinician signed off that a urinalysis was done but there was not an accompanying note by the clinician.

Infirmary Record Review	
Finding(s)	**Suggested Corrective Action(s)**
PH-10: A comprehensive review of 9 inmate records revealed the following deficiencies: **(a) In 2 records, there was no evidence that medications were administered according to the clinician's orders.** **(b) In 1 of 1 applicable record, there was no evidence of a discharge note for a 23 hour observation patient.** **(c) In 2 of 8 applicable records, the blue inpatient file was incomplete (see discussion).** **(d) In 2 of 7 applicable records, there was no evidence of a discharge note for inpatient admissions.**	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. Monitoring intervals may be modified to less often if results indicate appropriate compliance or correction. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Discussion PH-10(c): *In one record, the infirmary admission order sheet (DC4-714D) was missing. In another record, the orders were not signed by the physician.*

Consultations Record Review	
Finding(s)	**Suggested Corrective Action(s)**
PH-11: A comprehensive review of 15 inmate records revealed the following deficiencies: **(a) In 5 of 14 applicable records, there was no evidence the Chief Health Officer or designee approved the consultation request by signing the Consultation Request/Consultant's Report (DC4-702) (see discussion).** **(b) In 3 of 14 applicable records, there was no evidence that the consultation and/or follow-up appointments were initiated and completed in a timely manner (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. Monitoring intervals may be modified to less often if results indicate appropriate compliance or correction. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Discussion PH-11(a): *Health Services Bulletin 15.09.04 states that the DC4-702 must be signed by the Chief Health Officer or designee to approve the consultation request and that this form be completed so that the information is sufficient to obtain the needed consult. Surveyors were concerned that the lack of approval signatures and incomplete or inadequate information could cause unnecessary delays or denials in obtaining consultations.*

Discussion PH-11(b): *In one case, the inmate fell on 9/19/13 and was seen by medical staff that day complaining of right arm pain. A week later, on 9/26/13, an X-ray was done at the follow-up visit revealing a fracture of the right distal ulna and an orthopedic consult was requested. Even though the consult was marked "urgent", the appointment was made for 10/28/13. Surgery was then scheduled for 11/25/13, approximately 8 weeks after the fracture, requiring a plate and screws to repair the arm.*

In another record, an inmate with chronic kidney disease had been seen in clinic in September 2013 and a consultation request was made to evaluate and recommend plans for both diagnosis and treatment on 10/19/13. Neither the consultation request form (DC4-702) or the consultation log show that an appointment had been scheduled. As of the date of this survey, (14 weeks after the consultation request), the inmate had not received the requested consultation services.

In the last record, a 40 year old inmate with a history of glaucoma needed a follow-up consultation for medication monitoring. The inmate had previously been seen in April 2013. The consultation request was dated 11/15/13. The appointment date is blank on the DC4-702 and the consultation log for November states "pending UM review", making it difficult to determine the timeliness and result of the request. The inmate was seen, however, on 1/10/14, eight weeks after the request.

Medication Administration Record Review	
Finding(s)	**Suggested Corrective Action(s)**
PH-12: In 7 of 12 records reviewed, all code boxes were not filled in, signed, or initialed appropriately on the MAR.	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. Monitoring intervals may be modified to less often if results indicate appropriate compliance or correction. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Periodic Screening/Preventive Care Record Review	
Finding(s)	**Suggested Corrective Action(s)**
PH-13: A comprehensive review of 15 inmate records revealed the following deficiencies:	Provide in-service training to staff regarding the issue(s) identified in the Finding(s) column.
(a) In 3 records, the periodic screening encounter did not occur within one month of the due date.	Create a monitoring tool and conduct biweekly monitoring of no less than ten applicable records to evaluate the effectiveness of corrections. Monitoring intervals may be modified to less often if results indicate appropriate compliance or correction.
(b) In 6 records, the periodic screening was incomplete and did not include all required items (see discussion).	
(c) In 12 records, there was no evidence that required diagnostic tests were performed 7-14 days prior to the periodic screening encounter (see discussion).	Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.
(d) In 3 records, there was no evidence that the inmate was provided lab results at the time of the screening.	
(e) In 5 records, there was no evidence that health education was provided.	

Discussion PH-13(b): *Health Services Bulletin 15.03.04 states that the periodic screening encounter will include the following: vital signs measured and compared to the previous screening, weight measured and compared to the previous screening, review of the lab results, review of electrocardiogram (EKG) and mammogram results if applicable, identification of any inmate health concerns, confirmation that tuberculin skin test is current, screening for tuberculosis symptoms, collecting and testing of stool hemoccult cards if applicable, review of sick call access procedures, and the provision of health education. Three records were missing documentation of weight measured and compared to previous screenings; one of which was a diabetic inmate with a 12 pound weight gain. One record was missing documentation of vital signs. Another record was missing documentation of the stool hemoccult and confirmation that the tuberculin skin test was current. The final record was missing a review of the EKG and recommendations for follow-up. This inmate had a history of hypertension and entered the facility on 11/9/12 being treated with Lisinopril which is an ACE inhibitor drug used to treat elevated blood pressure and heart failure. His blood pressure was 142/86 at the time of the periodic screening. The clinical surveyor brought this to the attention of medical staff and the inmate was scheduled for the hypertension clinic to be seen on 1/22/14.*

Discussion PH-13(c): *Per Health Services Bulletin 15.03.04, the following diagnostic tests should be performed 7-14 days prior to the periodic screening encounter: CBC, dipstick UA, PSA if indicated, baseline lipid profile at age 40, random blood glucose by finger stick if*

indicated, EKG if clinically indicated, and stool hemoccult for those age 50 and over. In five records reviewed, the diagnostic tests were done after the date of the periodic screening. In seven records reviewed, the diagnostic tests were completed prior to the periodic screening but at intervals greater than the 7-14 days parameter.

Intra-System Transfers Record Review	
Finding(s)	**Suggested Corrective Action(s)**
PH-14: In 5 of 12 records reviewed, the Health Information Transfer/Arrival Summary (DC4-760A), was incomplete (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. Monitoring intervals may be modified to less often if results indicate appropriate compliance or correction. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Discussion PH-14: *In five records the transfer summary was not signed, dated, and/or signature stamped as required. One form was not dated, three forms were not signature stamped, and one form was neither dated nor stamped.*

Pharmacy Services	
Finding(s)	**Suggested Corrective Action(s)**
PH-15: The pharmacy storage area and pill line administration area did not contain adequate space for storage of inventories and work activities.	Provide evidence in the closure file that the issue described has 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.

Institutional Tour	
Finding(s)	**Suggested Corrective Action(s)**
PH-16: A tour of the facility revealed that was no evidence that the negative air pressure in the medical isolation room was checked daily (see discussion).	Provide evidence in the closure file that the issue described has 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.

Discussion PH-16: *Per protocol, negative air pressure in medical isolation rooms should be checked daily when in use. The room was occupied at the time of the survey. A monthly log was provided which showed that the room had not been checked since September 2013.*

PHYSICAL HEALTH FINDINGS – ANNEX

Taylor Correctional Institution-Annex (TAYCI-Annex) provides outpatient physical health services. The following are the medical grades used by the Department to classify inmate physical health needs at TAYCI-Annex:

- 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.
- M4 - Inmate is being followed in a CIC every three months and requires ongoing visits to the physician more often than every three months.

CLINICAL RECORDS REVIEW

CHRONIC ILLNESS RECORD REVIEW

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

EPISODIC CARE REVIEW

There were findings requiring corrective action in the review of emergency care and sick call. The items to be addressed are indicated in the tables below. There are no infirmary services provided at TAYCI-Annex.

OTHER MEDICAL RECORD REVIEW

There were no findings requiring corrective action in the review of intra-system transfers, preventive care, and the medication administration record review. There were findings requiring corrective action in the review of consultation services; the items to be addressed are indicated in the table 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 infection control, pharmacy services, and the administration of the pill line.

INSTITUTIONAL TOUR

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

Cardiovascular Clinic Record Review	
Finding(s)	**Suggested Corrective Action(s)**
PH-1: A comprehensive review of 15 inmate records revealed the following deficiencies: **(a) In 3 records, the baseline history was incomplete or missing (see discussion).** **(b) In 4 records, the baseline physical examination was incomplete or missing (see discussion).** **(c) In 3 records, the baseline laboratory work was incomplete or missing (see discussion).** **(d) In 3 records, there was no documentation indicating the control of the disease and/or patient status.**	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 to evaluate the effectiveness of corrections. Monitoring intervals may be modified to less often if results indicate appropriate compliance or correction. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Discussion PH-1(a, b, &c): *Baseline historical, diagnostic, and physical examination data was inadequately documented or missing altogether on many of the Chronic Illness Clinic Flowsheets (DC4-770). CMA surveyors noted that this baseline information would otherwise be difficult to assess, as it would require significant time to locate in other portions of the patient's medical record, particularly if the medical record was large or the patient was medically complex. Additionally, this baseline information would frequently be thinned from the medical record. Although, discussed here, this baseline information was missing from multiple other chronic illness clinics.*

Endocrine Clinic Record Review	
Finding(s)	**Suggested Corrective Action(s)**
PH-2: A comprehensive review of 12 inmate records revealed the following deficiencies: **(a) In 5 records, the baseline history was incomplete or missing.** **(b) In 5 records, the baseline physical examination was incomplete or missing.** **(c) In 1 of 4 applicable records, there was no evidence of an annual dilated**	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 to evaluate the effectiveness of corrections. Monitoring intervals may be modified to less often if results indicate appropriate compliance or correction. Continue monitoring until closure is affirmed through the CMA corrective action

Endocrine Clinic Record Review	
Finding(s)	**Suggested Corrective Action(s)**
fundoscopic examination. **(d) In 4 records, there was no evidence of pneumococcal vaccine or refusal.** **(e) In 2 of 9 applicable records, there was no evidence of influenza vaccine or refusal.**	plan assessment.

Gastrointestinal Clinic Record Review	
Finding(s)	**Suggested Corrective Action(s)**
PH-3: A comprehensive review of 12 inmate records revealed the following deficiencies: **(a) In 3 records, the baseline history was incomplete or missing.** **(b) In 4 records, the baseline physical examination was incomplete or missing.** **(c) In 2 of 9 applicable records, there was no evidence of influenza vaccine or refusal.** **(d) In 7 of 11 applicable records, hepatitis A & B vaccine was not given to inmates with hepatitis C infection and no prior history of A & B infection.**	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 to evaluate the effectiveness of corrections. Monitoring intervals may be modified to less often if results indicate appropriate compliance or correction. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Immunity Clinic Record Review	
Finding(s)	**Suggested Corrective Action(s)**
PH-4: A comprehensive review of 11 inmate records revealed the following deficiencies: **(a) In 9 of 10 applicable records, there was no evidence of hepatitis B vaccine or refusal.** **(b) In 8 records, there was no evidence of pneumococcal vaccine 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 to evaluate the effectiveness of corrections. Monitoring intervals may be modified to less often if results indicate appropriate compliance or correction. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Miscellaneous Clinic Record Review	
Finding(s)	**Suggested Corrective Action(s)**
PH-5: A comprehensive review of 9 inmate records revealed the following deficiencies: **(a) In 2 records, the diagnosis was not accurately recorded on the problem list.** **(b) In 5 records, the baseline history was incomplete or missing.** **(c) In 3 records, laboratory studies were not completed prior to the clinic visit.** **(d) In 4 records, there was no documentation indicating the control of the disease and/or patient status.** **(e) In 4 of 7 applicable records, there was no evidence of pneumococcal vaccine or refusal.** **(f) In 3 of 6 applicable records, there was no evidence of influenza vaccine or refusal.** **(g) In 3 of 6 applicable records, there**	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 to evaluate the effectiveness of corrections. Monitoring intervals may be modified to less often if results indicate appropriate compliance or correction. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Miscellaneous Clinic Record Review	
Finding(s)	**Suggested Corrective Action(s)**
was no referral to a specialist or the referral did not take place as indicated (see discussion).	

Discussion PH-5(g): *In the first record, an inmate was seen by an ophthalmologist on 6/12/12 who recommended cataract surgery on the inmate's left eye. No consultation request was completed until 12/9/13. The inmate's last clinic visit indicated "poor vision" and there had been almost two years separating clinic visits. The appointment had not yet been scheduled at the time of the survey. In the second record, an inmate with a long history of glaucoma was seen by an ophthalmologist on 8/31/12. On that visit, the physician requested that the inmate return to the clinic within six months to recheck his pressures. No consultation request was completed until 12/26/13 and no appointment had been scheduled at the time of the survey. In the last record, an inmate had an echocardiogram completed in 2012 which showed "severe systolic dysfunction" and an ejection fraction of 21 percent. This inmate was being followed in the respiratory and miscellaneous clinics. The CMA clinical surveyor expressed concern that the inmate's cardiac status was not properly addressed in the clinic documentation and that the inmate was not on any cardiac regimen (e.g. statin or aspirin therapy) and no contraindication was documented in the medical record.*

Neurology Clinic Record Review	
Finding(s)	**Suggested Corrective Action(s)**
PH-6: A comprehensive review of 4 inmate records revealed the following deficiencies: **(a) In 3 records, the baseline history was incomplete or missing.** **(b) In 6 records, the baseline physical examination was incomplete or missing.** **(c) In 2 records, seizures were not classified (see discussion).** **(d) In 1 of 1 applicable record, there was no indication that a medication taper was considered after two years without a documented seizure.**	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 to evaluate the effectiveness of corrections. Monitoring intervals may be modified to less often if results indicate appropriate compliance or correction. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Discussion PH-6(c): *Department policy requires that seizures be classified as primary generalized (tonic-clonic, grand mal), primary or simple absence (petit mal), simple partial or complex partial seizures.*

Oncology Clinic Record Review	
Finding(s)	**Suggested Corrective Action(s)**
PH-7: A comprehensive review of 2 records revealed the following deficiencies: **(a) In 1 record, the baseline history was incomplete or missing.** **(b) In 1 record, the baseline physical examination was incomplete or missing.** **(c) In 1 record, the baseline laboratory work was incomplete or missing.** **(d) In 2 records, there was no documentation indicating the control of the disease and/or patient status at the last visit.** **(e) In 2 records, there was no evidence of influenza vaccine or refusal.**	Provide in-service training to staff regarding the issue(s) identified in the Finding(s) column. Create a monitoring tool and conduct appropriate biweekly monitoring of no less than ten records to evaluate the effectiveness of corrections. Monitoring intervals may be modified to less often if results indicate appropriate compliance or correction. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Respiratory Clinic Record Review	
Finding(s)	**Suggested Corrective Action(s)**
PH-8: A comprehensive review of 11 inmate records revealed the following deficiencies: **(a) In 4 records, the baseline history was incomplete or missing.** **(b) In 6 records, the baseline physical examination was incomplete or missing.** **(c) In 3 records, reactive airway diseases were not classified (see discussion).** **(d) In 5 records, there was no evidence of pneumococcal vaccine 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 to evaluate the effectiveness of corrections. Monitoring intervals may be modified to less often if results indicate appropriate compliance or correction. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Discussion PH-8(c): *According to Departmental policy (HSB 15.03.05 Attachment #1), inmates with reactive airway diseases will be classified as mild, moderate, or severe.*

Emergency Care Record Review	
Finding(s)	**Suggested Corrective Action(s)**
PH-9: In 2 of 7 applicable records (11 reviewed), there was no evidence that follow-up appointments were initiated and/or completed in a timely manner (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 to evaluate the effectiveness of corrections. Monitoring intervals may be modified to less often if results indicate appropriate compliance or correction. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Discussion PH-9: *In the first record, an inmate with an extensive cardiac history experienced a syncopal episode. A consultation for AICD check at Reception Medical Center (RMC) was requested on 10/17/13. A second request for the same appointment was documented on 11/20/13. Additionally, there is an outstanding request for a carotid ultrasound. No appointments had been scheduled at the time of the survey. In the second record, an EEG was requested for an inmate with a history of seizures. The request was approved on 11/8/13 but no appointment had been scheduled at the time of the survey.*

Sick Call Record Review	
Finding(s)	**Suggested Corrective Action(s)**
PH-10: In 3 of 8 applicable records (14 reviewed), there was no evidence that follow-up appointments were initiated and/or completed in a timely manner (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 to evaluate the effectiveness of corrections. Monitoring intervals may be modified to less often if results indicate appropriate compliance or correction. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Discussion PH-10: *In one record, an urgent EKG was requested on 12/9/13 and had not been completed by the date of the survey. This record was brought to the attention of the institutional physician who discontinued the order. In the second record, an inmate was seen at sick call for*

visual complaints. The inmate was referred to the provider on 11/4/13 and seen by the provider on 11/27/13. On 12/4/13 an optometry consultation was placed but no appointment had been scheduled at the time of the survey. In the last record, an inmate was seen at sick call for visual complaints. The inmate was referred for an optometry consult on 10/18/13. No appointment had been made at the time of the survey.

Consultations Record Review	
Finding(s)	**Suggested Corrective Action(s)**
PH-11: A comprehensive review of 11 inmate records revealed the following deficiencies: **(a) In 3 records, the clinical information was insufficient to obtain the needed consultation services (see discussion).** **(b) In 5 of 7 applicable records, there was no evidence that follow-up appointments were initiated and/or completed in a timely manner (see discussion).** **(c) In 7 of 11 records, the consultation log was incomplete or inaccurate (see discussion).** **(d) In 2 of 3 applicable records, there was no new treatment plan following a denial by Utilization Management (UM).**	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 to evaluate the effectiveness of corrections. Monitoring intervals may be modified to less often if results indicate appropriate compliance or correction. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Discussion PH-11(a): *In the first record, an inmate with multiple complaints of abdominal pain was seen at RMC. On 10/8/13 the consultant physician recommended that an "urgent" endoscopy and colonoscopy be obtained. Documentation contained in the inmate's medical record indicated multiple attempts by Utilization Management (UM) at RMC to obtain additional information from the referring physician regarding the patient's medical history and current symptomology. The consultation was eventually discontinued by UM for lack of information. The patient continued to complain of abdominal pain and blood in stools and has since been seen in sick call.*

In the second record, an inmate saw a gastroenterologist on 9/27/13 who recommended an urgent colonoscopy. The colonoscopy was requested by TAYCI-Annex on 10/2/13 and marked "urgent". Multiple requests were sent by UM for additional clinical information with negative results. The consultation was discharged by UM for lack of clinical information.

In the last record, a request was sent for a liver biopsy for a patient with a history of hepatitis infection. The original request was sent on 9/18/13 and marked "routine". The procedure was denied by UM on 10/30/13 secondary to lack of sufficient clinical information.

Discussion PH-11(b): *In the first record, consultations were requested for an inmate with a complex hand fracture. The first request was dated 9/26/13 and marked "urgent/emergency". The second request was dated 12/12/13 and sent to UM along with an x-ray dated 12/5/13. The appointment had not been scheduled at the time of the survey.*

In the second record, an EEG and MRI were requested by a neurologist on 10/4/13 for an inmate with seizures. The MRI was denied but the EEG approved on 11/8/13. No appointment had been scheduled at the time of the survey.

In the third record, there were multiple consultations pending for an inmate with lung cancer (diagnosed in July 2013) and concerns for possible metastases. On 9/10/13 a pulmonologist requested a PET scan and CT scan with contrast "ASAP". On 10/2/13 the TAYCI-Annex physician requested the scans, along with additional consultations for oncology and pulmonology services, as per the consultant's treatment plan. No appointments had been scheduled at the time of the survey.

In the fourth record, an "urgent" consult was requested for an inmate with a history of abnormal EKGs on 8/22/13. Although, the consultation indicated there were concerns for ischemia or possible cardiomyopathy, this inmate was not evaluated by a cardiologist until 1/2/14.

In the last record, an "urgent" endoscopy was recommended on 10/23/13 for an inmate with a history of a duodenal ulcer and bleeding. The procedure had still not been scheduled at the time of the survey.

Discussion PH-11(c): *In the first record, the wrong specialty was listed. In the second record, the log did not indicate the completion of the consultation or the necessary follow-up. In the third record, the denial was not indicated. In the fourth record, not all of the pending consultations were noted on the log. In the fifth record, the completion of the consultation was not indicated. In the sixth record, neither the diagnosis nor disposition was indicated. In the last record, the consultation was left off the log entirely.*

Institutional Tour	
Finding(s)	**Suggested Corrective Action(s)**
PH-12: A tour of the facility revealed the following deficiencies: **Sick call/exam rooms:** **(a) The blood glucose meter was not being calibrated or logged.** **Inmate Housing areas:** **(b) Procedures to access medical and dental services were not posted in dormitory areas.** **(c) The required over the counter**	Include documentation in the closure file that appropriate in-service training has been provided to staff regarding the issues in the Finding(s) column. Provide evidence in the closure file that the issue described has 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.

Institutional Tour	
Finding(s)	**Suggested Corrective Action(s)**
medications were not available in all dormitory areas. **(d) Pill line schedules were not posted in all dormitory areas.**	

CONCLUSIONS – PHYSICAL HEALTH

MAIN UNIT

The physical health staff at TAYCI-Main serves a difficult population that includes inmates with multiple medical and psychiatric comorbidities. Physical health care is provided on an outpatient and inpatient basis. In addition to providing routine physical health care and inmate education, medical staff participates in continuing education and infection control. The physical health team reviewed 211 records and found deficiencies in 126 records, not all of which are findings requiring corrective action, as these issues did not represent a significant pattern. Reportable findings requiring corrective action are outlined in the tables above.

Upon arrival at the institution, the records needed for the physical health portion of the survey were readily available to the surveyors. Overall, documents appeared to be filed in a timely manner with the exception of some labs. Charts were generally organized in accordance with Department policy *(Health Services Bulletins 15.12.03)*, however, there were some documents that were misfiled, incomplete, or missing altogether. Several chronic illness clinic flowsheets were missing in the Endocrine, TB, and Respiratory clinics and some labs were not located in the Preventive Care records. Baseline history and physical information was frequently missing from chronic illness clinic records. Missing or incomplete documentation is a concern as lack of necessary clinical information in the medical record makes it more difficult to maintain continuity of care in an already complex and difficult to manage population

CMA surveyors noted several administrative deficiencies regarding medical record keeping and documentation of care. Two inmates were in the database as sick call encounters but were actually medical emergency encounters. Two records reviewed for periodic screening indicated the inmates had hypertension and should have been enrolled in the cardiovascular clinic but were not. Another inmate was enrolled in the respiratory clinic but had no respiratory diagnosis. While this issue does not require corrective action, the surveyors expressed concern as inmates who are not placed in the proper clinic may not be seen at appropriate intervals for their diagnosis making it difficult for abnormalities or complications to be addressed in a timely manner.

Interviews held with medical staff, correctional officers, and inmates indicated that all were generally knowledgeable about how to access both routine and emergency medical services. However, three inmates interviewed expressed dissatisfaction with medical services. While it is recognized that the inmate population may have an incentive to complain about services, when a significant number of inmates report similar concerns, further investigation may be warranted. One inmate transferred from the Annex to the Main Unit approximately two months prior to the date of this survey and stated he had not been seen since the transfer even though he had put in a sick call request. He did say he was called out for sick call but sat for seven and a half hours without being seen. The second inmate complained about the length of time it took for consultation services to be provided. The third inmate stated he had made several requests to see the doctor while trying to obtain work release status but finally had to file a grievance with the warden to get the issue resolved. It is not always possible to confirm or refute interview findings during a survey, but in this case, two of the three complaints were confirmed. Regarding the consultation complaint, according to the consultation logs, the inmate appears on the August log with an August request date but the appointment was not scheduled until November. In the other example given above, a copy of the grievance verifying approval by the warden was provided by the inmate.

Overall, CMA surveyors concluded that medical care commensurate with the expectations set forth by the Department's Health Services Bulletins is not being provided at TAYCI-Main. However, the institutional staff were receptive to the feedback provided by the CMA audit team and reported they would use the results of the survey to make the needed improvements.

ANNEX

The physical health staff at TAYCI-Annex serves a complex and difficult population, including inmates with multiple medical comorbidities and advanced age. Physical health care is provided on an outpatient basis. Inmates requiring infirmary services a/re transferred to the Main Unit. In addition to providing routine physical health care and inmate education, medical staff participates in continuing education and infection control activities. The physical health team reviewed 178 records and found deficiencies in 79 records, not all of which are findings requiring corrective action, as these issues did not represent a significant pattern. Reportable findings requiring corrective action are outlined in the tables above.

CMA clinical surveyors identified areas in which institutional documentation was out of compliance with Departmental policy. Baseline historical, diagnostic, and physical information was frequently missing from the chronic illness clinic flowsheets. Additionally, there were several cases in which flowsheets were not updated after the most recent chronic illness clinic visit. Incomplete documentation was also identified in the consultation logs. Many of the entries were missing key components. CMA surveyors stated throughout the survey that they had difficulty finding the necessary information and had to thoroughly examine many different areas of the medical record to find pertinent information. They expressed concern that the institutional clinicians, who are directly responsible for the provision of care, would not have the necessary time to do the same. Overall, surveyors noted that improved documentation could increase efficiency and help maintain continuity of care.

The most notable concerns were incomplete or inadequate follow-up for patients needing additional diagnostic testing or outside consultation services; several examples of which can be found in the chronic illness clinics, consultations, emergency care, and sick call services. Clinical surveyors noted exceptionally long wait times for specialty services and several instances in which the required clinical care was found to have not been initiated. Several inmates who have pending consultations have serious acute and chronic health conditions and there are concerns that long waits or missed opportunities for follow-up could have deleterious effects on their health status.

TAYCI-Annex has recently undergone many changes in personnel and staffing, including several key positions. Many of the staff members are new, and additionally, older staff members have had to take on new responsibilities and roles. This may have exacerbated or contributed to several of the deficiencies noted on this report.

Overall, the health care services provided at TAYCI-Annex are out of compliance with Department standards. However, institutional staff were receptive to the feedback provided by the CMA audit team and reported they would use the results of the survey to make the needed improvements.

MENTAL HEALTH FINDINGS – MAIN UNIT

TAYCI-Main provides outpatient mental health services. The following are the mental health grades used by the Department to classify inmate mental health needs at TAYCI-Main:

- S1 - Inmate requires routine care (sick call or emergency).
- S2 - Inmate requires ongoing services of outpatient psychology (intermittent or continuous).

SELF INJURY/SUICIDE PREVENTION REVIEW

There were no episodes of restraint at TAYCI. 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.

USE OF FORCE REVIEW

There were no findings requiring corrective action in the use of force review.

ACCESS TO MENTAL HEALTH SERVICES REVIEW

There were findings requiring corrective action in the review of special housing, psychological emergencies, and inmate requests; 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; 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)**
MH-1: A comprehensive review of 6 SHOS admissions revealed the following deficiencies: **(a) In 2 records, an emergency evaluation was not completed prior to an SHOS admission by mental health or nursing staff.** **(b) In 2 of 2 applicable records, the inmate was not evaluated by the 4th day of admission to determine the need for a transfer to CSU (see discussion).** **(c) In 4 of 5 applicable records, daily rounds by the clinician were not documented.** **(d) In 4 records, there was no evidence the attending clinician conducted a face to face evaluation prior to discharge from SHOS.** **(e) In 2 records, there was no evidence the inmate was seen by mental health staff for post-discharge follow-up (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 to evaluate the effectiveness of corrections. Monitoring intervals may be modified to less often if results indicate appropriate compliance or correction. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Discussion MH-1(b): *The Department's Health Service Bulletin (HSB) states that during the fourth day of SHOS, the attending clinician will personally evaluate the inmate and determine whether at that point, crisis stabilization care will be needed to resolve the mental health crisis. In both of the applicable records, there was no indication that this evaluation had been performed.*

Discussion MH-1(e)*: According to Department policy, mental health staff is required to see inmates within seven days for post-discharge follow-up. In the applicable records, there was no indication that the mental health staff performed the required follow up.*

Special Housing	
Finding(s)	**Suggested Corrective Action(s)**
MH-2: A comprehensive review of 14 records revealed the following deficiencies: **(a) In 4 records, the Special Housing Health Appraisal (DC4-769) was not present or not completed in its entirety.** **(b) In 11 records, the mental status exam (MSE) was not completed within the required time frame (see discussion).** **(c) In 1 of 2 applicable records, follow-up MSEs were not completed within the required time frame (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 to evaluate the effectiveness of corrections. Monitoring intervals may be modified to less often if results indicate appropriate compliance or correction. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Discussion MH-2(b&c): *The Department's HSB states that 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. The findings listed above did not meet the required time frames. Additionally, there were no initial MSEs present in eight records. One record was missing the follow-up MSE.*

Psychological Emergency	
Finding(s)	**Suggested Corrective Action(s)**
MH-3: A comprehensive review of 3 records revealed the following deficiencies: **(a): In 2 records, there was no documentation in the medical record indicating that an inmate declared a mental health emergency.** **(b): In 1 of 2 applicable records, there was no evidence the psychological emergency was responded to within 1 hour.**	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 to evaluate the effectiveness of corrections. Monitoring intervals may be modified to less often if results indicate appropriate compliance or correction. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Inmate Request	
Finding(s)	**Suggested Corrective Action(s)**
MH-4: In 2 of 6 records reviewed, a copy of the inmate request form 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 records to evaluate the effectiveness of corrections. Monitoring intervals may be modified to less often if results indicate appropriate compliance or correction. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Discussion MH-4: *If the request is not in the record, it cannot be determined if the request was answered appropriately.*

Outpatient Mental Health Services	
Finding(s)	**Suggested Corrective Action(s)**
MH-5: A comprehensive review of 12 outpatient (S2) records revealed the following deficiencies: **(a) In 5 of 12 applicable records, the consent for treatment was not signed prior to the initiation of treatment or renewed annually.** **(b) In 2 of 4 applicable records, the mental health screening evaluation was not completed within 14 days of arrival.** **(c) In 5 of 12 applicable records, the biopsychosocial assessment (BPSA) was not present and/or completed in the medical record.** **(d) In 2 of 3 applicable records, the individualized service plan (ISP) was not completed within 14 days of arrival.** **(e) In 4 of 10 applicable records, the ISP was not individualized and lacked**	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 to evaluate the effectiveness of corrections. Monitoring intervals may be modified to less often if results indicate appropriate compliance or correction. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Outpatient Mental Health Services	
Finding(s)	**Suggested Corrective Action(s)**
pertinent information. **(f) In 2 of 6 applicable records, the ISP was not signed by members of the Multidisciplinary Services Team (MDST) and/or inmate and there was no documented refusal (see discussion).** **(g) In 5 of 6 applicable records, the ISP was not reviewed or revised at the 180 day interval.** **(h) In 7 records, mental health problems were not documented on the problem list.** **(i) In 10 records, counseling was not provided at least once every 90 days for inmates not diagnosed with a psychotic disorder (see discussion).** **(j) In 10 records, case management was not conducted at least every 90 days (see discussion).** **(k) In 10 records, the progress notes were not of sufficient detail to follow the course of treatment.** **(l) In 10 records, the frequency of the clinical contacts was not sufficient and clinically appropriate (see discussion).**	

Discussion MH-5(f): *In two records, there was no psychologist's signature present on the ISP. According to staff interviews, there was some time (including the time of the survey) in which there was no psychologist on staff at the institution. According to staff, a psychologist has been hired and will be on-site three days per week.*

Discussion MH-5(i,j,&l): *In five records, there was no evidence that the inmate had been seen by mental health staff since his arrival at the institution. In the additional five records, the inmate had not been seen by mental health staff in more than 120 days.*

MENTAL HEALTH SYSTEMS REVIEW

Administrative Issues	
Finding(s)	**Suggested Corrective Action(s)**
MH-6: There was no Inmate Request Log kept between 8/20/13 and the day of the survey (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-7: There was no Psychological Emergency Log kept between 8/20/13 and the day of the survey (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-8: Weekly clinical supervision for the mental health professionals was not consistently conducted (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-9: There were no Multi-disciplinary Service Team (MDST) meetings held during 2013 (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.

Discussion MH-6&7: *There was no Inmate Request Log or Psychological Emergency Log kept between 8/20/13 and the day of this survey. Staff was able to provide a sample of inmates who placed an inmate request and those that declared a psychological emergency; however it was not possible to get a total and valid sample size due to the lack of a complete log.*

Discussion MH-8: *According to the information provided, there has been no clinical supervision at TAYCI during 2013 and there was no scheduled supervision being provided at the time of this survey.*

Discussion MH-9: *According to the information provided, there were no MDST meetings held during the entire 2013 year. In addition, at the time of the survey, there was no psychologist working (although one has been hired), which is a vital role in the MDST.*

MENTAL HEALTH FINDINGS – ANNEX

TAYCI-Annex provides outpatient mental health services. The following are the mental health grades used by the department to classify inmate mental health needs at TAYCI-Annex:

- S1 - Inmate requires routine care (sick call or emergency).
- S2 - Inmate requires ongoing services of outpatient psychology (intermittent or continuous).

SELF INJURY/SUICIDE PREVENTION REVIEW

There were no episodes of restraint at TAYCI-Annex. Inmates in need of admission to SHOS were moved to the Main Unit since there is no infirmary in the Annex.

USE OF FORCE REVIEW

There were no findings requiring corrective action in the use of force review.

ACCESS TO MENTAL HEALTH SERVICES REVIEW

There were findings requiring corrective action in the review of special housing, psychological emergencies, and inmate requests; 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; 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.

Special Housing	
Finding(s)	**Suggested Corrective Action(s)**
MH-1: A comprehensive review of 14 records revealed the following deficiencies: **(a) In 9 records, the mental status exam (MSE) was not completed within the required time frame (see discussion).** **(b) In 1 of 1 applicable record, follow-up MSEs were not completed within the required time frame (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 to evaluate the effectiveness of corrections. Monitoring intervals may be modified to less often if results indicate appropriate compliance or correction. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Discussion MH-1(a&b): *The Department's Health Service Bulletin (HSB) states that 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. The findings listed above did not meet the required time frames. Specifically, nine records had no initial MSE present in the medical record. One record was missing the follow-up MSE.*

Psychological Emergency	
Finding(s)	**Suggested Corrective Action(s)**
MH-2: A comprehensive review of 3 records revealed the following deficiencies: **(a): In 1 record, the intervention was not appropriate based on the presentation of the inmate (see discussion).** **(b): In 1 record, the disposition was not clinically appropriate based on the documentation in the medical record (see discussion).** **(c) In 2 records, there was no appropriate follow up in response to the psychological emergency (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 to evaluate the effectiveness of corrections. Monitoring intervals may be modified to less often if results indicate appropriate compliance or correction. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Discussion MH-2(a): *In one record, the inmate indicated that he wanted to hang himself and banged his head against the wall. The subsequent assessment and plan section were not filled out*

on the Mental Health Emergency Nursing Assessment. The inmate declared another psychological emergency later that same day and was subsequently admitted to SHOS.

Discussion MH-2(b): *In one record, the disposition was unclear because that section of the Mental Health Emergency Nursing Assessment was left blank.*

Discussion MH-2(c): *In one record, the inmate had not been seen since the declaration of the psychological emergency on 10/1/13. In the other record, there were no follow-up plans noted on the Mental Health Emergency Nursing Assessment.*

Inmate Request	
Finding(s)	**Suggested Corrective Action(s)**
MH-3: In 2 of 4 records reviewed, a copy of the inmate request form was not present in the medical record (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 to evaluate the effectiveness of corrections. Monitoring intervals may be modified to less often if results indicate appropriate compliance or correction. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

Discussion MH-3: *If the inmate request is not in the record, it can not be determined if the request was answered appropriately*

Outpatient Mental Health Services	
Finding(s)	**Suggested Corrective Action(s)**
MH-4: A comprehensive review of 14 outpatient (S2) records revealed the following deficiencies: **(a) In 5 records, the consent for treatment was not signed prior to the initiation of treatment or renewed annually.** **(b) In 5 of 7 applicable records, the mental health screening evaluation was not completed within 14 days of arrival.**	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 to evaluate the effectiveness of corrections. Monitoring intervals may be modified to less often if results indicate appropriate compliance or correction. Continue monitoring until closure is affirmed through the CMA corrective action

Outpatient Mental Health Services	
Finding(s)	**Suggested Corrective Action(s)**
(c) In 1 of 1 applicable record, the biopsychosocial assessment (BPSA) was not approved by the MDST within 30 days of the initiation of mental health services. **(d) In 2 of 2 applicable records, the individualized service plan (ISP) was not completed within 14 days of arrival.** **(e) In 8 of 12 applicable records, the ISP was not individualized and lacked pertinent information.** **(f) In 1 of 4 applicable records, the ISP was not signed by the inmate and there was no documented refusal.** **(g) In 7 of 7 applicable records, the ISP was not reviewed or revised at the 180 day interval.** **(h) In 4 records, mental health problems were not documented on the problem list.** **(i) In 13 records, counseling was not provided at least once every 90 days for inmates not diagnosed with a psychotic disorder (see discussion).** **(j) In 13 records, case management was not conducted at least every 90 days (see discussion).** **(k) In 13 records, the progress notes were not of sufficient detail to follow the course of treatment.** **(l) In 13 records, the frequency of the clinical contacts was not sufficient and clinically appropriate (see discussion).**	plan assessment.

Discussion MH-4(i,j,&l): *In six records, there was no evidence that the inmate had been seen by mental health staff since his arrival at the institution. In the additional eight records, the inmate had not been seen by mental health staff in more than 120 days.*

MENTAL HEALTH SYSTEMS REVIEW

Administrative Issues	
Finding(s)	**Suggested Corrective Action(s)**
MH-5: There was no Inmate Request Log kept between 8/20/13 and the day of the survey (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-6: There was no Psychological Emergency Log kept between 8/20/13 and the day of the survey (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-7: Weekly clinical supervision for the mental health professionals was not consistently conducted (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-8: There were no MDST meetings held during the entire year of 2013 (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.

Discussion MH-5&6: *There was no Inmate Request Log or Psychological Emergency Log kept between 8/20/13 and the day of this survey. Staff was able to provide a sample of inmates who placed an inmate request and those that declared a psychological emergency; however it was not possible to get a total and valid sample size due to the lack of a complete log*

Discussion MH-7: *According to the information provided, there has been no clinical supervision at TAYCI-Annex during 2013 and there was no scheduled supervision being provided during the time of the survey.*

Discussion MH-8: *According to the information provided, there were no MDST meetings held during the entire 2013 year. In addition, at the time of the survey, there was no psychologist working (although one has been hired), which is a vital role of the MDST.*

CONCLUSION– MENTAL HEALTH

MAIN UNIT AND ANNEX

The overall missions of both the Main Unit and Annex at TAYCI are similar and both areas are the responsibility of the same centralized mental health staff. Outpatient mental health services are provided at TAYCI Main and Annex. These services, including case management and individual counseling, were being provided to over 100 inmates. In addition to providing services to inmates on the mental health caseload, staff answer inmate requests, respond to psychological emergencies, provided daily assessments for inmates in SHOS on the Main Unit, and perform weekly rounds in confinement. Staff also perform sex offender screenings when needed.

The majority of the findings in the mental health area seem to be a reflection of the need for stable mental health staff. At the time of this survey, there was only one mental health employee who consistently provides services on both the Main Unit and the Annex. Although staff from other institutions are brought in to provide assistance, there are issues with the completion of assessments and provision of treatment.

Many of the records reviewed lacked important documents such as updated ISPs, BPSAs, consents for treatment, MSEs, and inmate request forms. In addition, many required clinical contacts were not documented (e.g., daily rounds and post-discharge follow-up in SHOS, mental health contact for inmates in special housing, counseling and case management contact for outpatient mental health services, and initial interviews within 14 days of arrival).
It appeared from entries noted in the Offender Based Information System that inmates were seen by mental health staff at times, but there was no corresponding documentation in the record. Additionally, interviews with inmates were inconsistent. For example, one inmate expressed satisfaction with mental health treatment while another reported no mental health contact since his arrival. The lack of clinical documentation in the medical record and inconsistent information gleaned from inmate interviews make it difficult to follow the course of treatment.

Several inmates indicated (either through interview or documentation in the record) their desire and perceived need for psychiatric medication. According to staff, inmates must first receive an evaluation from a psychologist before a referral to a psychiatrist can be made. Staff indicated that this position has been vacant; therefore these inmates have not been evaluated. One inmate interview revealed that he had been trying to get his psychiatric medication since September of 2013 and has had both psychological emergencies and SHOS admissions during that time. Another inmate's record contained mental health records requested from the jail in early 2013 indicating he had been prescribed psychotropic medication. Additionally a post-it note indicating the need for a physician review was attached to the records. There was no documentation of follow-up or review after that time. An interview with mental health staff revealed that there were "at least a few" inmates who have a need for evaluation for a possible referral to a psychiatrist and they will be referred when appropriate clinical staff is available.

Based on the findings listed above it appears that mental health care commensurate with the expectations set forth by the Department's Health Services Bulletins is not being provided at TAYCI Main and Annex. A significant number of the findings may be related to the need for more staff. Staff indicated a psychologist has been hired who will be on-site three days per week and a position for a fulltime Behavioral Specialist is being advertised.

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.